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1 November 2003

New Charter 'unacceptable' says SOS lobby

Generics plans 'cherry picking' says BAPW

No guarantee for pharmacy oxygen supply

Diagnostics, pharmacy, and the genome

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acogenetics is likely to ect the new diagnostic aking on

With a single stroke 34
Argyll pharmacist Jeanette Smith found herself on the receiving end of care when she recently suffered a stroke. She talks about the experience

Second Charter 'unacceptable'

The Save Our Society group says the second draft Charter is "unacceptable" as it does not include the intention to promote the interests of members.

Instead, the SOS group says that the revamped draft Charter, put out for consultation on October 17, refers only to safeguarding the interests of the profession of pharmacy. This could "render the Society virtually powerless to pursue the interests of pharmacists", claims the SOS group, which points out that, currently, the Charter makes this "an important and distinctly stated aim of the Society".

A document issued on Monday by SOS members Hassan Argomandkhah, Maurice Hickey, Mark Koziol, Gavin Miller and Graham Phillips adds that the second draft Charter does not define the profession. "This means that someone who is not a pharmacist but can demonstrate that he or she works in pharmacy could claim that the Society should promote and safeguard their interests alongside the interests of pharmacists." This could lead to huge conflicts of interest, says the group.

It is "unacceptable" that the second draft creates the potential for other categories of membership to include non-pharmacists, subject to the approval of the Privy Council, continues the document. The group is also concerned that the Government, in the shape of the Privy Council, could alter the composition of the Council.

RPSGB Council member and communication lead on the Charter Andrew Burr is offering to debate the new Charter with members of the SOS group at a local level (*see letters, p14*). Pharmacists only have until November 14 to submit views on the second draft as the Council intends to have the new Charter agreed at its December meeting.

RPSGB president Gill Hawksworth said: "The Council fully intends to maintain, and even increase, the Society's current representational role."

However, she added: "The revised draft Charter does not define the profession of pharmacy because we need the Charter to be enabling and flexible." As such, it would make it possible for different membership categories to be created in the future.

RETAILING

Shopping centre pharmacies warning

Nearly 400 shopping centres in England will be able to open limitless numbers of pharmacies, threatening community pharmacy says a Liberal Democrat MP.

According to Brian Cotter, the Liberal Democrat spokesman on small business, 389 large (over 15,000sq m) shopping centres in England will be able to open unlimited numbers of pharmacies because they would be exempt from the proposed restrictions on community pharmacies entering the market.

"Over the last decade pharmacy numbers have remained stable, with around 50 pharmacies opening and closing annually. Under these proposals there is nothing to stop every one of these large shopping centres from opening one or more new chemist overnight, marking an eight-fold increase," said Mr Cotter.

Mr Cotter said that those hit hardest will be the elderly and those unable to travel.

BAPW says generics plans amount to 'cherry picking'

by Fiona Salvage
fsalvage@cmpinformation.com

The Government's generics consultation proposals are "the worst example of cherry picking" and it may become unviable for wholesalers to distribute generic products as a result, claims an industry association.

The British Association of Pharmaceutical Wholesalers was responding to the Department of Health's proposals on the supply and reimbursement of generic medicines. BAPW condemned the DoH's proposals, saying that they failed to address the need for pharmacists and wholesalers "to make profit in some sectors to cover substantial loss-making activity in others".

Steve Dunn, the BAPW's chairman, said that the DoH's proposals may mean that supply of generic medicines to patients will be severely disrupted as pharmacists and wholesalers reduce their holding of generic stock prior to a possible price cut in April 2004. He added that profitability issues could mean that wholesalers may not stock a complete range of generics, which would lead to supply problems for pharmacists and patients.

This problem could extend into a permanent issue with pharmacy contractors unable to carry certain lines because it is no longer economically viable, the BAPW claims. Mr Dunn said: "The supply of generics should not be taken in isolation but in a holistic way with regard to other arrangements for remuneration of contractors."

Mr Dunn reiterated the BAPW's argument that a reduction in generic pricing should be gradual to minimise supply chain risk and any shock to the market. He said that the association's members were not always the cheapest option for popular products, but were "often the only source for the slow, unpopular products". Any reduction in return on generic items will mean that wholesalers no longer stock a complete range of pharmaceuticals, he claimed.

In BAPW's response to the DoH, Mr Dunn said that if generic prices are cut, wholesalers will lose out whereas community pharmacies will be compensated through payments for service.

BAPW suggests that the existing generic maximum price scheme should be used as the basis for selecting items as this would remove items with low sales and keep the regulatory burden low.

POLICY

Pharmacists 'leaving in droves'

North-East London Local Pharmaceutical Committee has warned the Government that community pharmacists are becoming demotivated, with owner managers leaving in droves.

In its response to the Department of Health's *Vision for Pharmacy*, the LPC points out that – with increased prescribing – pharmacists are working without parallel increases in resources.

"Pharmacists are working longer hours, taking shorter holidays and cutting investment in their businesses. Morale among pharmacists is dangerously low and without urgent action the NHS faces the potential for large-scale and unplanned closures of pharmacies."

The LPC has focused on the pharmacist's role in improving public health, tackling inequalities and contributing to community development and regeneration.

Diwali was celebrated in style last weekend by an estimated 60,000 people at the Shri Swaminarayan temple, Neasden, London. Pharmacists Nik Patel, [illegible] and [illegible] Patel gave up their weekend to provide medical cover at the celebrations for the "festival of light", the most important day in the Hindu calendar. This is a common occurrence for the three pharmacists as they have taken responsibility for co-ordinating the medical unit at the temple, ensuring sufficient numbers of health professionals are available for such functions. Pictured [illegible], a display of some of the 1,500 vegetarian dishes taken to the temple as religious offerings.

PRACTICE

Pharmacists cannot be oxygen link, says DoH

Pharmacists should tender for domiciliary oxygen service contracts when they are drawn up, but cannot be the professional link between hospital and patient, the Department of Health has said.

In June, the Government announced that changes would be made to the existing domiciliary oxygen therapy service. These mean that GPs will no longer have responsibility for ordering long-term oxygen therapy and the service would transfer to specialist consultants in hospitals. GPs would continue to prescribe small amounts for palliative care.

According to the DoH's deputy pharmaceutical officer Jeanette Howe, the new model's aim is to provide a "modern domiciliary oxygen service based on a patient's need and requirements rather than on how it is delivered". She added that community pharmacists should submit tenders for these contracts if they can meet the specifications for a "safe and effective service to patients".

Ms Howe said in her response to a letter from Sultan Dajani, secretary of Lambeth, Southwark and Lewisham LPC, that the DoH had "no intention to 'insinuate that the current systems have impeded technological advances or that community pharmacy cannot advance practice'."

She said there were problems with Mr Dajani's suggestion that pharmacists could become the professional link between the respiratory hospital consultant and the patient and the GP could "opt out of the oxygen loop". The GPs' ultimate responsibility for their patients' care, she said, means that they will need to stay informed of their patients' treatment and other health needs, even if the oxygen is prescribed by a hospital doctor or a pharmacist.

● PSNC has written to patients using oxygen to ask their views on the service being removed from community pharmacies. PSNC wrote to contractors in September to canvas their opinions.

Lindsay McClure, PSNC's head of prescription information who is collating the project, said that the response from contractors had been "fantastic" and that PSNC hoped to have the survey results within a few weeks.

The questionnaire for patients has been sent by PSNC via independent pharmacies and to some of the CCA's members. Ms McClure said the response seems to be good and the results should be ready by mid-November.

New PSNI president

Kate McClelland has been elected president of the Pharmaceutical Society of Northern Ireland. She has stepped up from vice-president to succeed Sheelagh Hillan.

After graduating from Queen's University Belfast, Dr McClelland worked as a lecturer while doing her PhD, then as a community pharmacist. She was elected a council member of PSNI in 1996 and became vice-president in 2001.

Apply now for BPC Practice medal

The Royal Pharmaceutical Society is inviting applications for the 2004 British Pharmaceutical Conference Practice Research Medal, sponsored by *C&D*.

The award recognises individuals aged up to 45 years who have contributed significantly to pharmacy practice research. The winner will be invited to deliver a lecture at BPC 2004 and will receive a cheque for £1,000.

Applications and nominations should be forwarded by December 31 to Judy Callanan, Practice Research Secretariat, RPSGB, 1 Lambeth High St, London SE1 7JN.

Script fraud down 12pc

The estimated cost of prescription fraud in Northern Ireland has fallen by £1.2 million over the last three years. Government figures put the estimated cost of prescription fraud at £9.5 million for 2000-2001, £8.6m for 2001-2002 and £8.3m for 2002-2003. The figures include patients erroneously misclaiming prescription levy exemption, as well as deliberate defrauding.

NPA & PCPA draw up guidelines

Two pharmacy associations have developed guidelines to help PCTs draft briefing papers for executive committees on how to plan strategy for community pharmacy in light of future developments.

The National Pharmaceutical Association and the Primary Care Pharmacists Association have developed a template paper, which includes an executive summary and a briefing paper. The executive summary can be adapted and used to inform the PCO professional executive committee and board on subjects such as the new pharmacy contract, *A Vision for Pharmacy* and the NHS modernisation proposals.

For more information:

www.npanet.co.uk
www.pcpa.org.uk
www.druginfozone.nhs.uk

Ask the president

RPSGB president Gill Hawksworth answers questions on the Society's modernisation process.

Why is the Society seeking a new Charter?
The current Charter is, in a number of respects, out of date. Also, the Government is preparing legislation governing the Society (the Section 60 Order), as it has for other health professions.

If the Charter were not updated, the reform programme would be implemented solely through the new legislation, which would take precedence over the Charter and effectively over-write it. Simply amending the current Charter would have produced a piecemeal, confusing document that would not be fit for purpose. Hence, the Council decided that a new Charter was the best solution.

Updating the Charter alongside the legislation will ensure a robust framework to secure the Society's integrated professional and regulatory remit well into the future. This will enable us to maintain and to strengthen our key functions of professional leadership and development.

What is the Section 60 Order?
It is legislation made under section 60 of the Health Act 1999. A Section 60 Order can create or amend legislation governing a health professional regulator, to secure or improve the regulation of the profession or the services which the profession provides or to which it contributes.

What are the time limits for completing the above two consultations?
The Council has taken over 250 policy decisions to inform the Section 60 Order. These are now with the Government, which plans to issue its draft legislation for public consultation early next year.

We need to let the Government know what we want to see in the Charter before it produces its draft legislation. The Council will need to take some decisions on the new Charter in December 2003. Comments on the revised draft Charter need to be sent to the RPSGB by November 14.

Send your Charter queries to the president via C&D at chemdrug@cmpinformation.com

MS risk sharing scheme falls behind 10-year target

by Fiona Salvage
fsalvage@cmpinformation.com

The multiple sclerosis risk sharing scheme has not enrolled enough patients in time to generate useful information within its 10-year timespan, claims Schering Health Care.

Patient enrolment is running well, but is short of its target and won't produce enough viable long-term data, said a spokeswoman for Schering. Patient uptake into the scheme has not been quick enough, especially in certain blackspots, she said.

The spokeswoman said that if the scheme is to generate the necessary long-term data, the Department of Health needs to extend the length of the risk sharing scheme past the current 10 years. But the Department of Health said: "After a slow start, substantial progress has been made. Decisions about extending the scheme will be taken at a later date if necessary."

Rosie Winterton, health minister, answered a question in Parliament recently on the number of multiple sclerosis patients who were receiving disease modifying treatments (DMT). She said that 6,300 patients were receiving DMT at the end of August, increasing by approximately 300 patients each month. However, this number also includes patients who were on DMT prior to the risk sharing scheme.

A spokesman for the MS Society said enrolment into the scheme hadn't happened as speedily as the society would have liked, with certain parts of the country moving faster than others. He added that the MS Society was encouraged, though, to see an increase in the speed of prescribing and uptake.

The number of patients within the cohort group – important to the manufacturers because this is generating the valuable data – is significantly (36-50 per cent) below target, with only 2,600 enrolled at the end of August. The target number of patients to be recruited into the cohort group is between 5,500 and 7,000.

● The Multiple Sclerosis Society is looking for businesses that are willing to display its Christmas tree star decorations, for which customers can donate £1.

For more information:
www.mssociety.org.uk

Boots voices remote supervision doubts

The Boots Pharmacists' Association shares similar doubts to other pharmacy organisations about the proposal for remote supervision of pharmacies (*C&D, October 25, p14*).

While supporting the delegation of the accuracy check to qualified technicians, the BPA says it is essential for a pharmacist to maintain the pharmaceutical assessment. A possibility would be to compile a list of items that could be supplied by suitably qualified technicians without the pharmacist's personal supervision. This could include repeat items previously assessed by the pharmacist, at the same premises and clinically unchanged. But there would need to be robust protocols in place.

"The Association could not support the idea of a single pharmacist being accountable for more than one pharmacy," the BPA said, adding that it would be "delighted" to embrace new roles but wants the Government to recognise that community pharmacy's main role is to provide and be accountable for safe and accurate dispensing.

Questiontime

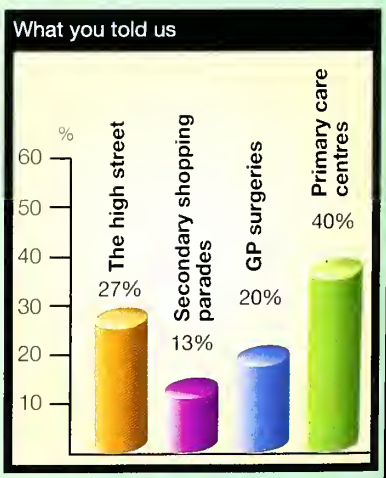
Sponsored by UniChem

Last week we asked you: "Changes to stamp duty on leases will threaten pharmacies' viability. Which location is the most secure to safeguard pharmacies?" You replied (see right):

This week's question: Which if the following diagnostic services do you think most suitable to be provided through community pharmacy?

● HIV ● Herpes ● Breast cancer ● Predisposition to Alzheimer's ● Fertility ● Paternity

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on November 4 to cast your vote. We will publish the results in *C&D*, November 8.



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INDUSTRY

Pfizer reorganises global divisions

by Sasa Janković
sjankovic@cmpinformation.com

Pfizer has reorganised its Global Research and Development, Global Pharmaceuticals and Global Manufacturing divisions under the new name of Pfizer Human Healthcare.

Pfizer chairman and chief executive officer Dr Hank McKinnell, who will chair the new organisation, said: "Over the past four years, we acquired two global healthcare companies – Warner-Lambert and Pharmacia – and divested a group of non-core businesses to focus even more intensely our core human pharmaceuticals business.

"Pfizer's continued success in the pharmaceutical business hinges on the alignment of our research, commercial and manufacturing operations. Increasingly, our strategies and tactics span all three of these groups, and to meet our global business objectives we are moving now to integrate them with closely co-ordinated planning and action. Our primary goal is end-to-end alignment across the full range of our global pharmaceutical business.

"Pfizer will continue to invest in our core businesses to sustain them as leaders in their respective fields and to keep them as vital contributors to our growth."

Pfizer UK said it foresaw no immediate impact from the change.

The company's third quarter revenues grew 56 per cent to £7 billion, compared to the same period in the prior year.

Its human pharmaceutical operations generated revenues of £6.5bn, up 57 per cent, in the third quarter. Sales of Pfizer's Consumer Healthcare business were £472m in the third quarter, up 31 per cent. Pfizer's Animal Health sales increased 56 per cent in the period to £259m.

Pfizer has recently entered into a global agreement with Organon, the human pharmaceutical business unit of Akzo Nobel, for the exclusive worldwide development and marketing of Organon's asenapine, a potential new psychotropic medication for the treatment of a variety of disorders that is beginning phase 3 trials in schizophrenia and bipolar disorder.

INDUSTRY

Agfa minilab goes digital

Agfa has launched its first digital minilab suitable for community pharmacies.

The compact, digital d-lab.1 is capable of print production from analogue or digital images, including CD services.

The machine is based on the "walk-away printing" concept, allowing operating staff to do other work in between processing jobs due to the simple operation.

Features including an automatic image enhancement system and new printing technology have been designed to guarantee printing quality with minimal operator intervention. The minilab can process 25 mixed jobs per hour.

Training and marketing support will be offered to retailers upon purchase, and finance options are available.

The Agfa d-lab.1 will be available from January 2004.

For more information:
Agfa-Gevaert Ltd
Tel: 020 8231 4903.

RETAILING

Lloyds launches flexible benefits scheme

Lloydspharmacy has launched a flexible employee benefits scheme called Benchmark, running initially until March 2004 for all pharmacists.

A second phase will be rolled out in April 2004 for area managers.

All employees will be presented with a variety of benefit options such as buying or selling holiday entitlement, life assurance, medical cover for dependents and lease car option.

Employees can receive these benefits at the start of their career, at the annual scheme renewal in February or as an existing employee where a lifestyle change has taken place.

Vicenta Rose, head of personnel, said: "We recognise that all employees have varying needs and lifestyles and our new flexible benefits scheme is tailored to meet those needs.

"We are also aware that retaining staff is key to the success of the business."

She concluded: "We feel that by offering a wide range of benefits, people will see Lloydspharmacy as an employer that is proactive in providing a workplace that focuses on and caters for the changing needs of individuals within the organisation."

INDUSTRY

More medicines available online

Rosemont Pharmaceuticals has launched a website for pharmacists with a Rosemont account to place orders online at *www.rosemontpharma.com*.

A list of the specials which are supplied by Rosemount can also be obtained by logging onto the website.

Site visitors can also find details about Rosemount's range of educational services.

Any pharmacist wanting to open an account can do so by logging onto the website. The first 50 pharmacists placing an order using this new service will receive a free Specials Recording Book.

WHOLESALING

Nucare amends incentives

Nucare has responded to the Government's plans to publish details of pharmacy suppliers' inducement schemes (*C&D, October 25, p9*), saying its own has grown because of the support it receives from its 1,200 independent pharmacy members.

However, managing director Mahesh Shah admits it has made some changes to its Share Incentive Scheme.

The original scheme included activities which promoted buying a wide range of products, including medicinal products, from a number of nominated suppliers with whom Nucare has negotiated special arrangements.

Mr Shah said: "Nucare considers that it is not in breach of the Medicines Advertising Regulations and its view is strongly supported by leading legal counsel. Nevertheless, Nucare is keen to work with the MHRA and has decided to amend the scheme in response to the MHRA's concerns.

"The scheme has been amended so that now all medicinal products are excluded. The original scheme was not designed nor intended to influence the pharmacists' professional judgement at all. The amended scheme has been approved by the MHRA and meets Nucare's objectives."

The amended scheme became effective from September 1, 2003 and has attracted over 20 new subscribers. Participating members have an option to subscribe for one ordinary share of 10p for every 20 points accumulated at 50 per cent discount when Nucare next makes a public offering of shares.

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*IRI February 2003

COVONIA

YOU CAN FEEL IT WORKING

Self-diagnostics is on the rise

by Sasa Janković
sjankovic@cmpinformation.com

A new report from Mintel claims an increasing number of people are opting for self-diagnosis and turning their backs on doctors.

In 2002 almost £55 million was spent on self-diagnostic products such as blood pressure monitors, blood glucose monitors and pregnancy tests. Five years ago this figure was just £40m. By 2007 Mintel expects this amount to rise to well over £60m.

"These days many people are much more aware of their health and often want to try and prevent illnesses before they start, rather than taking medicine once the illness has kicked in," said Jenny Catlin, consumer analyst at Mintel International. "They also realise that spotting the symptoms early on can really improve the chances of remaining healthy."

Today 58 per cent of British people have at least one self-diagnostic product in their home. People aged between 25-34 are most likely to have three or more self-diagnostic products.

"People seem a lot more willing to self-diagnose and to treat common health problems. This suggests that encouraging people to become better informed about their health and to seek other sources of reliable advice, such as from a pharmacist, is leading to greater self-reliance," adds Ms Catlin.

Blood glucose monitors, mainly used by people with diabetes, have seen the highest rates of sales growth over the past five years, with sales increasing by 65 per cent. Recently there has been an increase in the number of people with diabetes, possibly as a result of rising levels of obesity in the UK, which will have boosted this market, suggested Mintel.

For more information:
www.mintel.com

GSK results up but no news on pay row

GlaxoSmithKline's third quarter results show pharmaceutical turnover grew 10 per cent to £4.6 billion in the quarter, driven by US turnover growth of 14 per cent.

GSK successfully launched two key products into the US market in the period. Levitra, for erectile dysfunction, has captured over 12 per cent of new prescriptions in its sixth week on the market; and Wellbutrin XL, for depression, represents 19 per cent of new Wellbutrin prescriptions in its fifth week on the market.

Astham treatment Seretide/ Advair, GSK's largest product, continues to perform well, with sales up 40 per cent in the quarter.

Chief executive JP Garnier said: "We had an extremely good performance this quarter. Of course, the launch of generic Paxil late in the quarter will have an adverse impact on future sales. However, the continued strong growth of our key products clearly demonstrate the commercial strength of our business."

However, Mr Garnier did nothing to dispel rumours that he may request compensation if he has to bow to shareholders calls for a cut in his bonus package.

IVAX First official launch

Today sees the official launch of IVAX Pharmaceuticals UK's IVAX First pricing programme that delivers a range of products, at competitive prices. IVAX products are now available at a net market price to all pharmacists and dispensing doctors in the UK, via its wholesalers, with no sign up or data release requirements.

For more information:
www.ivaxfirst.co.uk

Boots opens new prescription warehouse

Boots has opened a prescription medicines warehouse at its Nottingham site, which the company says is already accurately completing 99.8 per cent of orders received.

Warehouse D80 uses a combination of automated and hand picking to complete its orders, which pharmacists must submit by 6pm for next day delivery by 9am. As each delivery enters the computer systems via radio frequency scanners on arrival, stock levels are kept in real time and pharmacists can see exactly what the warehouse is holding.

This system has other advantages too, according to Steve Eastham, Boots's head of clinical governance. Because pharmacists only need to order items when necessary there should be less wastage, he claims. This also has advantages should there be a drug recall alert. The system is able to tell warehouse staff which products are in stock and where they are located, helping them to identify quickly the items to be removed.

D80 is Boots's first warehouse to have all non-managerial staff employed on the same grade and with an annualised working hours contract. The 200 D80 staff were mostly recruited from outside Boots, with some of the managerial staff relocated from the former prescription medication warehouses in Aldershot, which has closed; and Heywood, which now supplies only non-prescription stock.

Two go as Boots restructures

Boots has restructured its management team in a bid to "simplify and focus the leadership of the business".

Andy Smith, director for HR, has resigned and leaves with immediate effect. Ann Francke, strategic marketing director, also leaves.

David Kneale, currently chief operating officer, takes the new role of chief commercial officer with responsibility for trading, marketing and formats. A new role of retail director has been created.

Paul Bateman, currently operations director, takes a new combined role with responsibility for human resources, logistics and manufacturing. Howard Dodd, chief financial officer, takes the additional responsibility of the property portfolio.

Chief executive Richard Baker says the smaller executive team will help the company speed up the progress it is already making on re-focusing the business."

Please e-mail your views to chemdrug@cmpinformation.com

Council must regain control of Lambeth and the decision-making process

It is my assertion that today the Council of the RPSGB is no longer in control of the affairs of the Society – our Society.

The problems started in 1998 when the Society adopted its 'new ways of working'. This led to a situation where Council members spent more time on committees aided by non-elected 'experts' and less time working collectively as a democratically elected Council.

The result of this is that today the Council is no longer the cohesive, informed, decision-making democratic body that it used to be. Prior to 1998, most of the articulating was done in the Council chamber. Here, firmly held, perhaps even non-conformist Council member views being aired constituted the process that we call democracy at work. It was hard work but it worked and it was seen to be done.

The 'new ways of working' ensure that the Council is now given proposals and it discusses them in an entirely new format. This involves unofficial away days in off-site locations, a heavy input from the non-elected 'experts' and, more recently, a big involvement from increasing numbers of members of staff.

These away days are not formal Council meetings, have no constitutional significance and they mean that Lambeth can manage any problems that may be occurring with 'non-PC' Council member views.

It means that when any decisions are actually asked of the full Council at formal meetings, they may be presented in small bite size chunks that in themselves seem fairly innocuous, but when put together could constitute something utterly unacceptable.

It is not difficult to envisage how such a process can lead to the dislocation from the decision-making process of our elected representatives, and also how it can allow non-elected individuals to have a wholly disproportionate influence over the affairs of the Society.

The real catastrophe is when this dislocation occurs in relation to issues which are of huge significance to the future of our profession, like the new Charter and modernisation.

There are many signs that indicate that this is the case:

- The Society's non-elected 'experts', some of whom are non-pharmacists turning up to the Society's AGM and vocifcrously lambasting genuine members for their concerns over the Society's modernisation plans, calling them Luddites.
- One influential non-elected 'expert' from the modernisation steering group sitting on the platform at the debate at the BPC comparing the quality of the modernisation debate within the profession to a recent argument that he witnessed at his local golf course about parking spaces.

These outbursts no longer seem like the cool advice of detached and reasoned experts but more like the rantings of people who have got too close to their own gameplan and are determined to get their way.

Surely, our elected representatives would never address the members or the issues in the same way, as they would be well aware of what the consequences would be.

Indeed, three senior Council members were ousted at the last election and were replaced by SOS candidates and no doubt the same will happen again next year.

At the BPC during the debate on modernisation, I alleged that a response to a Branch Reps' motion concerning modernisation which had been tabled at the August Council meeting was not the report which eventually ended up being published (*C&D September 27, p4*). The Society convened an internal investigation (*C&D October 11,p4*), the content of which I have not been given and this has led to:

- a further redraft of the wording, to correct 'misinterpretation'; and
- a formal complaint being lodged with the President from a member of Council.

Despite these developments, staff at Lambeth were cleared of any wrongdoing as the report allegedly points to the wide scope of authority and interpretation which members of staff now enjoy.

For members, the Society's modernisation process has often seemed like an experience of astonishingly frustrating proportions. Surely the time has come when the most important task that faces the Council is to regain control of Lambeth and take charge of the decision-making process?

If the Council fails to do this, then it will continue to be punished at election time for decisions that may have been manufactured elsewhere, and the profession will continue to move in a direction which does not meet with the members hopes, aspirations or approval.

Mark Koziol, SOS campaign.

Offering the chance to talk on modernisation issues

I read with interest the announcement by Hassan Argomandkhah, on behalf of the SOS campaign, to seek a petition for a referendum on the revised Charter (*C&D October 25, p4*).

In a further development Messrs Argomandkhah, Hickey, Koziol, Miller and Phillips issued a statement outlining several points they wish to contest (*see p6*).

I am not aware how much involvement, other than the Special General Meeting, these individuals have had in the extensive consultation process to date, nor whether they have attended the regional or branch meetings held across the country.

As the communication lead on the Charter, I feel the time has come to address these issues face to face at the local branch level. I would therefore welcome the opportunity to share a platform with each of these individuals at their local branch to debate the issues they regard as contentious.

It is important that we all understand the significance of the new Charter and why this should be dovetailed with the new legislation in order to secure the Society's integrated remit as the professional and regulatory body for pharmacy.

I have written to each of the individual members concerned and their respective branches to establish whether the local members of the branch feel such a debate would be helpful.

It is vital that the membership is not led down a blind alley and that we do not create problems f ourselves that will hold the profession as a whole back in the future.

Andrew Burr, communication lead on the Charter.

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Nothing works faster than Zovirax® Cold Sore Cream to treat the tingle or bust the blister of cold sores.[1,3,4] Zovirax helps soothe pain within an hour of application[5] and cuts cold sore healing time by up to half.[1,2] You and Zovirax together – what a great team.*

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Zovirax Cold Sore Cream Product Information
Presentation: 5% w/w aciclovir in water miscible cream base. **Uses:** Treatment of Herpes Simplex virus infections of the lips and face (cold sores). Dosage and administration: Apply 5 times a day for 5 days. It is important to start treatment as early as possible after the start of infection, ideally during the tingle phase. If healing has not occurred, treatment may be continued for up to an additional 5 days. **Contraindications:** Known hypersensitivity to aciclovir or propylene glycol. **Precautions:** Only to be used on cold sores on the lips and face. Do not apply inside the mouth or in the eye. Do not use for herpes infections of the eye or the genital area. Do not use if the patient is under the care of a doctor because of a weak immune system. Consult doctor if pregnant or breast feeding. **Side effects:** Transient burning or stinging may follow application. Mild drying or flaking of the skin has occurred in about 5% of patients. Erythema, itching and contact dermatitis have been reported rarely following application. **Legal category:** P. **Product licence number:** 00003/0304. **Product licence holder:** The Wellcome Foundation Limited, Greenford, Middlesex, UB6 0NN, U.K. **Further information available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 2 g tube - £5.79; 2 g pump - £5.99. **Date of last revision:** March 2003. Zovirax is a registered trade mark of the GlaxoSmithKline group of companies.

References:

1. Spruance SL *et al.* Antimicrob Agents Chemother 2002; **46**(7):2238-43. 2. Spruance SL. Seminars in Dermatology 1992; **11**(3): 200-206. 3. Van Vloten WA *et al.* J Antimicrob Chemother 1983; **12**(Suppl B): 89-93. 4. Fiddian AP et al. Br Med J 1983; **286**: 1699-1701. 5. Data on file, GlaxoSmithKline, 2001.

Comment from the Editor

The continued campaign against the RPSGB's method of modernising itself and the profession has picked up energy with the second draft of the proposed new Charter.

One of the key concerns expressed by the Save Our Society group is that the revised Charter does not seek to promote specifically the interests of members. Instead, if adopted, the Society's remit will be to represent the profession of pharmacy, presumably meaning all those who work in the field, and not just pharmacists.

The SOS stance has plenty of support – as witnessed at June's SGM – and although the revised draft Charter takes on board many of the concerns that have been expressed, it seems the Society's founding principles *per se* are no longer viable.

Unfortunately, the haste with which this is all coming together – driven by the Government's expectation that it will carry on in the new year with its health regulation reforms – means that the Society's Charter, the foundation on which rests its professional and regulatory principles, may not be as sufficiently robust as may be intended.

The Society's hurried consultation process – less than a month from the draft being issued to the closing date for responses – means that much will be overlooked. Don't forget the idea of the Society being able to seek charity status has only been put on the back burner, not dismissed in perpetuity. The current draft before members has nothing in it to exclude the matter being revisited once the dust settles.

A side issue for some, but like much of this whole process, it is easy to form the impression that Lambeth would prefer the membership not to get too involved in the running of the Society as it might upset some people's career plans. Who, exactly, is running pharmacy? Pharmacists, the Government or, as at least one former Council member suggests, pseudo civil servants at RPSGB HQ Lambeth doing much of the Government's bidding?

The Society's hurried consultation process ... means that much will be overlooked

Yourviews

Will the risk share scheme for MS drugs meet its targets, asks Mark Gibson

Could do better: one year on with MS trial

November will see the first assessment of the DoH's 'risk sharing scheme' for the provision of disease modifying therapies (DMTs) for multiple sclerosis.

More than just covering the supply of the treatment, the risk sharing aspect of the scheme collects performance data from a large patient cohort that will be used to help determine the long-term cost of these therapies.

Under considerable pressure in May 2002, the DoH needed to show that it was making progress in provision of MS treatment. Although no cure, DMTs have the capability to cut the number of attacks, limit their severity and delay progression of MS. The UK (at 4 per cent of patients on treatment pre-scheme) is way behind providing access to these therapies compared to the USA (47 per cent) and other European countries (17-33 per cent).

Mark Gibson: good news and bad

An estimate of 9,000 qualifying patients was agreed and set as an informal target, potentially boosting treatment levels to over 10 per cent. The latest prediction is that around 7,000 patients will be on treatment by November.

Although clearly short of the goal, it demonstrates progress. The possibility that the number of treated patients could have almost doubled will certainly be presented positively by the DoH.

But for the long-term supply of DMTs to be available at the right price, the stakeholders need the data from the cohort as early as possible. Here the news is not so good. The numbers of patients in the cohort by November will be between 35 and 50 per cent behind target. Agreeing and running a consistently high quality process for measuring patients' entry into, and their progress on the scheme has also been problematic.

One learning point is that expectations for how quickly the scheme could be set up were too ambitious. It appears the deadline for patient recruitment will need to be extended as stretched primary care trust budgets, ill prepared processes and over-burdened neurologists struggle to keep up with the scheme's goals.

The fact that the UK has only half the number of neurologists needs has been a bottleneck that isn't easily overcome.

For the patients who received treatment, the scheme has clearly been good news. But there are still thousands who would qualify for treatment but who have yet to receive it. Sadly, some may find that by the time they get access to the drugs their condition may have worsened to a point where they wouldn't qualify for them.

None of this means that the scheme is bad or that people have deliberately got in the way of a truly innovative idea. But it does raise questions about the cost, flexibility and consistency with which the industry can respond to genuine demand for effective therapies in this country.

Mark Gibson is VP & general manager, Specialist Care, Scherin Health Care.

Northern Ireland NOTEBOOK

To absent friends ...

It's good to remember times past and friends gone, so a recent *C&D (September 20)* was a poignant reminder of two good friends; one by his obituary and one by a photograph celebrating his Memorial Fund.

Billy Gorman slipped away quietly during the summer. My sympathy to his wife and family. Billy was synonymous with post-war pharmacy in Northern Ireland. He was PSNI secretary from the 1950s to the 1980s. It's strange to think that he retired nearly 20 years ago; I'm delighted he had time to enjoy a long retirement.

In his quiet unassuming way Billy made a huge contribution to the profession. He was central to organising the BPC conference in Belfast in 1969, a time of considerable civil strife, but the show did go on. He worked diligently to bring about our transformation to a degree entry profession in 1971. The Pharmacy

... Billy made a huge contribution to the profession

Order 1976 taxed his political skills and he set up the current pre-registration system with the help of Professor D'Arcy.

Billy was coy and politically astute but always the gentleman. My lasting memory is of him seated in the Society's office clouded in a fog of pipe smoke.

The Ronnie McMullan Trust is a lasting tribute to another pharmacist no longer with us. Ronnie was larger than life, gregarious and a wonderful ambassador for us all. And no more so than at BPC. He was known by so many as the face of Northern Ireland pharmacy.

In his memory, PSNI now sends a young pharmacist to experience the BPC. Ronnie would have had no other way and it is pleasing to see that both the first and second recipients are female. I'm sure Ronnie would have approved.

Written by a practising pharmacist in Northern Ireland

TOPICAL REFLECTIONS

No money, no vote and no vision

Money seemed to dominate last week's pharmaceutical press. Superficially it was the various reported responses to the Government's latest 'vision' for pharmacy but, ultimately, "pay and we will deliver" was the clear message regardless of the source of the response.

Whether the Government will listen and inject the necessary finance remains to be seen, but what is transparently clear is that without new money the change to a quality driven, service based pharmaceutical service will just not happen. And it was not just in the vision responses that money was seen as being of such pivotal importance.

At a reported AAH briefing in London, marketing director Mandeep Mudhar highlighted the reluctance of PCTs to take community pharmacy seriously and to put pharmacy high on their agenda. A polite way of saying better to ignore pharmacy than to have to commit their precious budget to the development of pharmaceutical services.

Then Steve Dunn, group managing director, warned that the unilateral proposal to claw back £200 million by reducing the tariff reimbursement for four key generics would directly affect present service provision and throw doubt on its continuation into the future.

As a statement of the obvious, Steve Dunn's remarks were breathtaking in their simplicity. Remove an average of £6,000 of my NHS remuneration and that is £6,000 less that I will have to invest in pharmaceutical service. The harsh reality is that I do not trust the Government, the Department of Health or my local PCT. They all want a pharmaceutical 'vision' paid for out of my money.

Promises are still on the table but lessons have still not been learned from past mistakes. Unilaterally reducing my income will not encourage my future co-operation. It merely confirms my belief that pharmacy is still being cynically abused. I will need a lot of persuading before I vote in favour in the second ballot for a new contract if that contract does not deliver a cast iron guarantee of improved resources immediately and fair play in the future.

An audit trail for a No Regs CD

I deal with a number of registered substance misuse clients and, for most of them, dispense methadone mixture on a daily basis. Recently my local substance misuse centre has started to prescribe Subutex (buprenorphine) sublingual tablets for its more stable clients, again on a daily basis.

When these clients first presented, my technician innocently asked why the Subutex prescriptions despite being 'CD' were not entered in the register. I explained that bupenorphine was not considered sufficiently addictive to warrant full register entry but on later reflection wondered whether this innocent question had exposed a weakness in the CD control.

Here was an opioid drug, originally POM, that was reclassified in its original 'Temgesic' strengths of 0.2mg and 0.4mg as 'POM CD no register' because of its potential for abuse. It was subsequently found to be of use at higher strength in the stabilisation of, and sometimes in a reduction programme for, some opioid drug misusers.

A client group whose behaviour patterns are notoriously difficult to monitor are now being dispensed, without records, an opioid drug that had previously been rescheduled 'CD' because of its potential for abuse. The increased workload required to manage buprenorphine as a full 'CD' would be no less than if these clients were taking their originally prescribed methadone. There appears to be little advantage in not having to register each dispensing but the audit trail that register entry provides any potential future investigation of use has been lost. An innocent question maybe, but one that should perhaps be reconsidered in the light of current usage.

The Advantage disadvantage

IVAX has finally seen the light and stopped its unnecessarily complex Advantage membership scheme. I have never been an advocate of this scheme and since its inception my purchases of IVAX products have substantially declined. Now that it has at last ceased perhaps IVAX reps can be allowed to sell their portfolio of generics using simple sales techniques I understand: good packaging, consistency of supply and competitive prices. I welcome IVAX back. Advantage: RIP.

First class

With competitive prices, consistent quality and excellent product availability, why settle for second when you can have first?

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We know that because we car
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IVAX first

In his third artiele on skin infeetions, *Dr Mike Wyndham* describes how to deteet and treat those caused by baeteria

Bacterial skin infections

The skin has several resident bacteria including *Propionibacterium acnes*, *Staphylococcus epidermidis*, diphtheroids and Gram-negative organisms. Generally these commensals cause no problems unless they attach themselves to man-made interventions such as catheters.

The main causes of problematic bacterial skin infection are *Staphylococcus aureus* and *Streptococcus pyogenes*. Pseudomonas may also be involved.

About 20 per cent of the population carry *Staph aureus*. The organism is commonly found in the nose but may also be found in the armpits, buttock area and groin. Patients who have had surgery or are receiving haemodialysis, people with diabetes, intravenous drug users or those suffering from HIV disease are more likely to be carriers. The bacteria may be easily transferred by hand. Certain groups are more at risk, such as neonates.

The carrier rate is higher in hospitals and institutional care such as nursing homes. Recurrent infection is more likely in diabetes, patients on steroids or those who have poor nutrition. Skin infection with *Staph aureus* is most common in the first and fourth decades and affects men more than women.

Streptococcus pyogenes is better known as Group A streptococcus (GAS). Streptococci are classified into groups according to their surface antigen, which helps with identification. So Group A is associated with skin infection, whereas Group B is associated with neonatal infections such as pneumonia and meningitis. The organism may be found on the skin and in the upper respiratory tract. Infection usually results from the micro-organism entering through breaks in the skin.

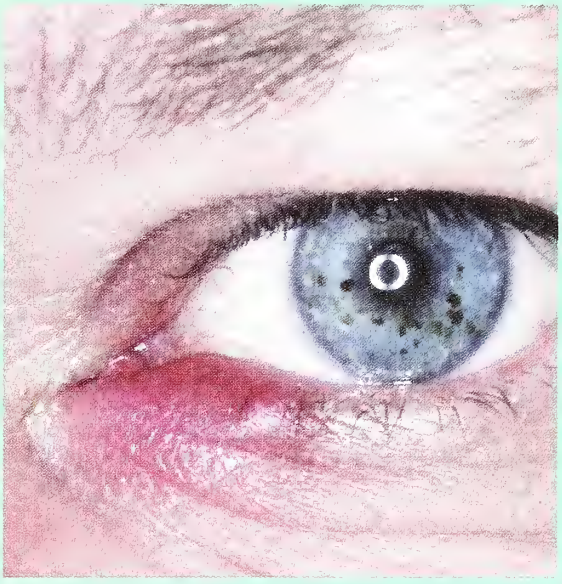
[illegible]

This condition is also known as keratolysis plantar. The sufferer is usually someone who wears trainers for much of the day. The shoes make the feet perspire heavily and the socks become soaked, maintaining an unhealthy damp environment. The skin becomes infected with the organism *Micrococcus sedentarius*. On removing the shoes, there is usually an unpleasant odour. The skin of the sole has a soggy, wet appearance and there are visible pits. The skin under the toes and the metatarsal heads are the areas most commonly affected.

The most essential element of treatment is to encourage the sufferer to wear occlusive footwear for a shorter time. It is probably not realistic to advise a teenager to stop wearing trainers entirely. Twice daily soaks of 15 minutes duration with either 1:4,000 potassium permanganate or 5 per cent formaldehyde solution should cure the condition.

[illegible]

Erythrasma is a superficial infection of the skin, most commonly occurring in early adult life and caused by *Corynebacterium minutissimum*. Men are affected more than women. The infection may be found in the axillae, groin, anogenital area and under the breasts, that is, where there are opposing areas of skin. It may occur between the toes and look similar to tinea pedis. The rash manifests as pale red-brown areas that may be wrinkly and scaly. The skin may itch but not always.



Pictures supplied by Dr Mike Wyndham

The organism responsible produces porphyrins. The rash fluoresces a coral pink colour under Wood's light (ultraviolet).[2] It can be treated with creams such as miconazole that are both antibacterial and antifungal, antibacterials such as fusidic acid applied topically, or oral antibiotics such as erythromycin.

[illegible]

Folliculitis

This is a pustular infection of the hair follicle producing discrete lesions. It is more common in men and affects the shaving area of the face (sycosis barbae), legs, buttocks and neck. Women tend to develop the problem after having their skin waxed. Eczema and psoriasis sufferers using potent steroids are also at risk.

Furunculosis

A furuncle (boil) is a more advanced form of folliculitis. Here there is much more inflammation and the erythema (redness) spreads out to the surrounding skin. There is more pus and pain than in folliculitis and the lesions may break down and discharge.

Boils have a predilection for the head, neck, legs and buttocks. This may result from staphylococcal carriage in the nose, axillae and anogenital areas.

I was taught always to check for diabetes in someone who suffers recurrent boils. However, I have never found any of my patients who have recurrent boils to be diabetic.

When there is infection of adjacent hair follicles with boils, the deeper tissues may become inflamed, resulting in a carbuncle. The most common places for this to occur are the shoulders, back, neck and legs. A stye should be considered as a boil affecting an eyelash and appears on the eyelid margin. This helps to differentiate it from an infected meibomian

Continued on page 20 ▶

cyst or chalazion, which is a swelling in the upper eyelid caused by blockage of an oil-secreting gland.

Boils usually clear without treatment, but sufferers can relieve the pain by holding a cotton wool ball or clean cloth, soaked in hot water, to the area for 30 minutes four times a day. Magnesium sulphate paste, covered with a dressing, can also help draw the infection to the surface.

Styes can be soothed by holding cotton wool soaked in saline over the area, and an antiseptic eye ointment may be used twice daily for a month to prevent recurrence.

Ecthyma

Crusts lie over small, ulcerated, well-demarcated lesions.[1] Poor physical status such as malnutrition, trauma, insect bites, poor personal hygiene, diabetes and immunocompromised states such as HIV disease are said to predispose to the condition. The cause may be *Staph aureus* but *Strep pyogenes* may also be implicated. Several lesions may be present at one time and are usually found on the lower legs.

Acute paronychia

An acute paronychia is an infection around the nail bed. The hand nails and great toenails are the most commonly affected. It usually results from infection entering through broken skin. Nail biting and picking at the cuticles are major causes. In the feet, picking or poor cutting of toenails predisposes to infection.

There is pain and redness and, when the infection persists, the soft tissues become swollen and pus may collect, creating an abscess. Incision and drainage is the first line of treatment. A swab should be taken and antibiotics given.

Impetigo

In this country, *Staph aureus* is the main cause of impetigo although *Strep pyogenes* may be responsible. It occurs most commonly in children and is significantly contagious, so is a reason for exclusion from school. It is most likely to occur where nasal infection develops following an upper respiratory tract infection.

This acts as a reservoir for the infection to spread elsewhere, either from parental nose wiping or from the patient picking at the dry crusts that develop. Other likely sufferers are patients with eczema who have a high

staphylococcal carriage. Care should be taken at home to avoid spread, by using separate bath towels and flannels.

Two types of lesion may be seen. The bullous ones are usually caused by staphylococcal infection and the crusted ulcer is caused by streptococcus. However, sometimes it is clinically difficult to differentiate between the two. The blisters are thin-walled and break down easily, leaving an open area which crusts a golden-yellow colour. The infection may spread easily with satellites of infection visible. Eczema herpeticum, where herpes simplex infects areas of eczema, must be considered in the differential diagnosis.

Role of *Staph aureus* in eczema

In atopic eczema, *Staph aureus* is found in 90 per cent of the skin where eczema is active and 30-75 per cent of areas where the skin appears normal, compared with up to 20 per cent for the normal population. Areas of weeping skin have the highest carriage.

It has been suggested that the micro-organism may promote acute flare-ups of eczema, even where no clinical infection is visible, with the production of exotoxins which act as superantigens. Half the strains of *Staph aureus* isolated from atopic eczema have been found to produce superantigens. Conversely, topical steroid preparations may reduce the colonisation of eczema by the bacterium and clobetasol may remove the organism entirely.[3]

Randomised trials of patients with atopic eczema, comparing the use of topical steroid versus a topical steroid/antibiotic combination, have usually found no clinical benefit of the latter. Additionally, hypersensitivity to antibiotics is a genuine risk. Neomycin is a common sensitiser, while fusidic acid only affects 0.3-1 per cent of users.

Antibiotic resistance is a growing problem. Resistance to fusidic acid ranges from 8-17 per cent, and is even higher (34 per cent) in patients attending hospital dermatology clinics. It is recommended that short courses of up to two weeks of combined treatment be used to try to reduce resistance. *The Drug and Therapeutics Bulletin* suggests using oral antibiotics such as flucloxacillin where there are clear signs of infection, along with topical steroids.[5,6]

MRSA

By 1948 *Staph aureus* (a Gram-positive bacteria (was resistant to penicillin in 60 per cent of cases. Resistance fell with the development of newer antibiotics, but by the 1950s multi-drug resistant strains of *Staph aureus* had evolved. Resistance to methicillin developed after one year of use in the early 1960s (MRSA). Today, antibiotics such as linezolid may be used for MRSA infections.

Studies have suggested that risk factors for the carriage of MRSA include previous hospital admission, exposure to ampicillin or ciprofloxacin, being in a nursing home prior to admission, and presence of pressure areas or wounds. Hospital workers may also carry MRSA.

MRSA may be associated with pneumonia, urinary tract infection in patients with urinary catheters, and septicaemia. These will require treatment, usually in hospital, with the most appropriate antibiotic.

Consultation with the lead microbiologist may be required to determine the first-choice antibiotic. Where there is an outbreak in a hospital ward, staff should be checked for nasal carriage. Any carriers are usually treated with mupirocin nasal ointment.

Infection control is clearly important and simple hygiene practices should not be forgotten. MRSA can be spread by hand, so hand washing is important.[4]

Erysipelas

Erysipelas is an acute infection with *Strep pyogenes* affecting the dermis and upper subcutaneous tissue. This is different from cellulitis, which is thought to affect all the subcutaneous tissue as well as the dermis. In erysipelas, the attack may be preceded by fever, 'flu-like symptoms and malaise. The rash, a well-demarcated red area, then follows and blisters may form. Sites commonly affected include the face and leg. The elderly are at particular risk.

There may be recurrent episodes affecting the same area and symptoms may precede the signs. Ask patients to remind you if they should suffer similar symptoms again, to facilitate early treatment.

Cellulitis

Cellulitis may be caused by either *Strep pyogenes* or *Staph aureus*. The redness seen in the infection is not as well demarcated as in erysipelas. It may result from opportunistic infection through breaks in the skin as found in oedematous legs or around the webs of the feet where there is fungal infection.

Streptococcal infection may cause an inflammation of the peripheral lymphatic vessels that results in a visible red line in the skin. This is known as a lymphangitis.

Treatments

Treatment of bacterial skin infection clearly depends on the causative organism. Swabs should be taken where possible for sensitivity. When the infection is staphylococcal, then flucloxacillin is the treatment of choice. This needs to be taken four times a day and may be difficult for a child attending school. Co-amoxiclav is an alternative as it can be given three times a day. For those who are penicillin sensitive, a

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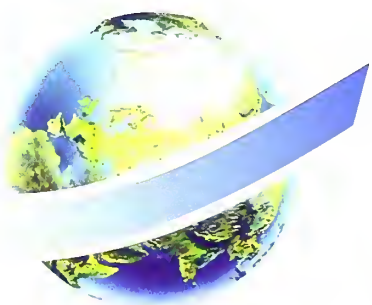
Number 18: Citalopram

The eighteenth in a series of reference cards for pharmacists



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Citalopram

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Citalopram is one of the most frequently prescribed SSRI antidepressants. It has been described as 'cleaner and safer' than the rest, though this may be perceptual. Certainly citalopram has fewer drug interactions than most SSRIs and hence has been favoured for prescribing in the elderly.

20mg daily as a single dose (morning or evening)
Increased to a maximum of 60mg daily (40mg if elderly)

Initially 10mg daily, increased to 20mg (after one week)
Usual dose 20mg-30mg daily. Maximum of 60mg daily (40mg if elderly)

GI effects - nausea, vomiting, dyspepsia, diarrhoea, constipation
Weight and appetite disturbances
Rash, urticaria and angioedema. *Caution: this could be an allergic reaction!*

- Women are twice as likely to suffer from mild depression as men
- Severe depression affects men and women equally
- With women the incidence of depression peaks in 35-45 year age group
- For men the incidence of depression continually increases with increasing age
- Incidence of depression is lower in married people than single people
- Depression accounts for £4 billion annually in lost working days
- Depression accounts for a further £7 million in NHS treatment

Citalopram

While clinical depression affects one in 20 individuals in the UK, only 3-4% will suffer from severe depression. However, only one in five will seek medical treatment. Recognising the symptoms of depression is therefore of primary importance.

Mood

Sadness, misery, gloom, anxiety, tension, lack of enjoyment, lack of affection, weeping, irritability

Physical

Feeling run down, tired, aches and pains, loss of appetite, loss of weight, sleep disturbance (early waking and difficulty sleeping), loss of libido, inability to relax, dysmenorrhoea, constipation

Thinking and drive

Lack of self esteem, sense of apathy and futility, inability to cope, shame and hopelessness, self-blame and worthlessness, wish to escape, derive no pleasure from activities, compulsive rituals (one in five)

Diagnosis and classification of depression

Psychiatrists currently use two systems to diagnose and classify mental health illnesses

- The ICD-10
- The DSM-V

ICD-10

International Classification of Diseases (WHO)

Consists of **three defining criteria:**

Is the **depressive episode,** according to a list of 10 symptoms (many shown above) present for at least two weeks? Four symptoms indicate an episode, six indicate a moderate episode and eight indicate a severe episode. Other illnesses and substance misuse/abuse effects have to be excluded.

The ICD-10 also specifies **somatic syndromes** that may also be present.

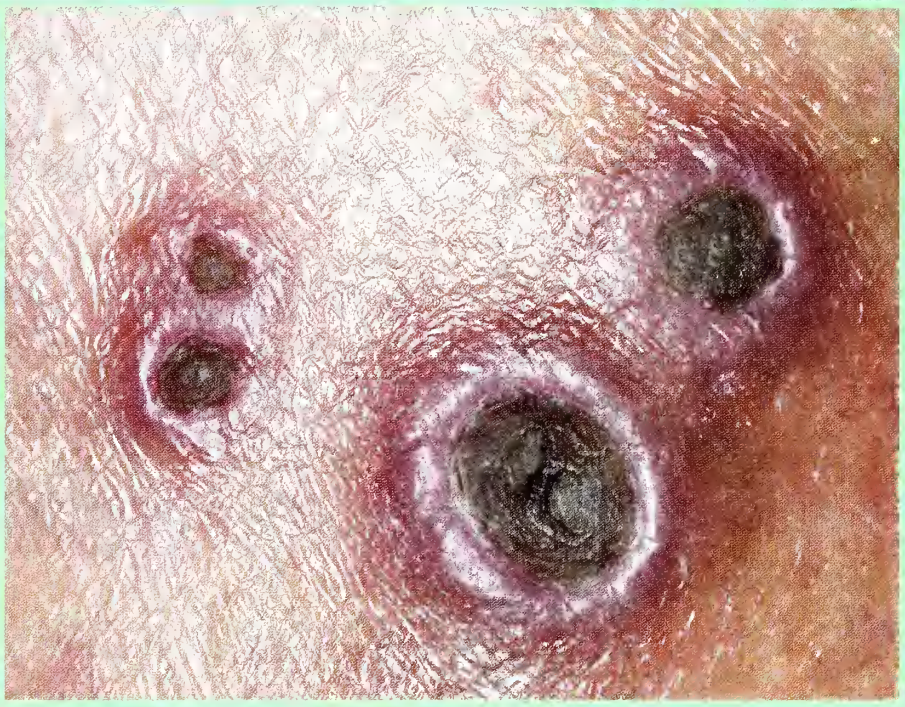
The presence of delusions or hallucinations would be specified under **psychotic symptoms**.

DSM-V

Diagnostic & Statistical Manual of Mental Disorders (6th Revised Edition) USA

Adopts a **multi-axial approach** to diagnosis:

- **Axis I** clinical (delerium, dementias, drug related, schizophrenia, depression, anxiety and somatoform)
- **Axis II** personality (paranoids, antisocial, OCD and mental retardation)
- **Axis III** general medical (endocrine, tumours, congenital, injury, infections & parasites)
- **Axis IV** psychosocial (education and occupational problems, housing and economic problems)
- **Axis V** global functions (reporting the clinician's judgement of overall level of functioning)

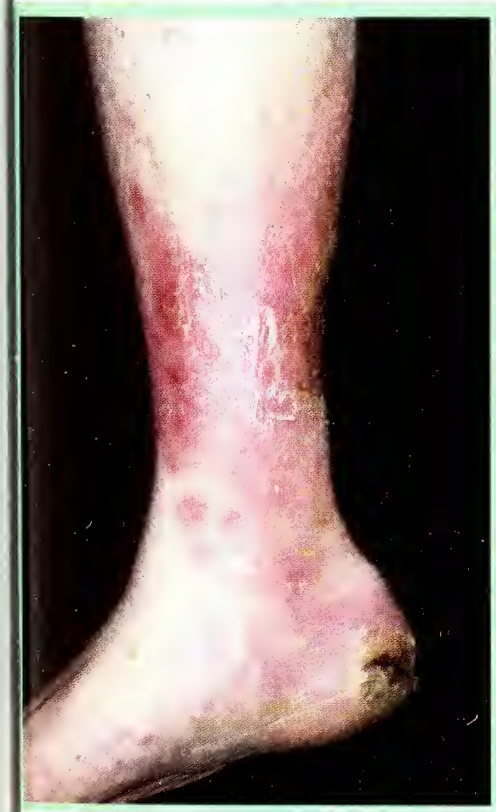


macrolide such as erythromycin or clarithromycin would be appropriate.

For streptococcal infections, penicillin is a suitable choice. If there is a problem complying with four times daily dose then moxycillin might be an alternative. Where there is doubt about the cause of an infection, as in cellulitis, then a combination of flucloxacillin and penicillin is appropriate.

Impetigo can be hard to treat as the infection is so easily spread. Oral treatment can be combined with topical treatment such as mupirocin or fusidic acid. Where possible, patients should cover the lesions with dressings (particularly if it is a child) to try to prevent the skin being picked and the spread of infection.

Where there is recurrent staphylococcal infection, it is worthwhile taking swabs from areas such as the nose, axillae and the groin to exclude carriage of staphylococcus.



Necrotising fasciitis

Necrotising fasciitis is an extremely dangerous condition. It is more common in patients with diabetes and occurs as a result of infection usually with more than one organism.[8] The causative organisms vary but may be a combination of anaerobic and aerobic bacteria. In polymicrobial infection, streptococci and enterobacteriaceae were the most common organisms identified by one centre, while Group A Strep was most commonly identified in monomicrobial infection.

Identifying the patient with early necrotising fasciitis may be difficult, as it does not have obvious distinguishing symptoms and signs.[7] There may be oedema, blistering and fever and, more significantly, pain that is disproportionate to the physical appearance.

Toxins released by the infecting organisms lead to skin necrosis, septicaemic shock and multi-organ failure. Early surgical debridement is essential to reduce mortality. Antibiotics are also important but take second place to surgery. Negative factors for outcome include old age, delay in surgery and the patient having other illnesses such as diabetes.

Pseudomonas infection

Pseudomonas may cause infection of hair follicles. Jacuzzis are a common source of infection as they have high bather use to volume of water. The patient may notice a rash of pustules on an erythematous background, affecting the skin exposed to the water. The condition may cause a fever and develops one to two days after bathing. A swab should be taken for culture. The illness may resolve spontaneously but those patients who are particularly unwell may be treated with ciprofloxacin.

Pseudomonas infection is a common cause of otitis externa and responds to gentamicin eardrops. It is a common contaminant of wounds such as varicose ulcers, and may appear secondary to onycholysis of the nails caused by fungal infection. Cultures should be taken where possible and appropriate topical preparations used, such as chloramphenicol.

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Dr Mike Wyndham MB, BS, DRCOG, MRCGP, is a former GP trainer and now joint conrse organiser for Barnet Hospital Vocational Training Scheme for general Practice. He is the scheme's edncational lead for dermatology.

Aspirin withdrawal linked to CHD events

Patients with coronary artery disease who stop taking aspirin may be at risk of withdrawal-related coronary events, French researchers have said.

A study of over 1,200 patients hospitalised for coronary syndromes found that over 4 per cent had discontinued aspirin treatment only one week before suffering an acute coronary event such as unstable angina or heart attack.

Prior to this, patients had been taking aspirin for at least three months and had not had an unstable coronary event, despite a history of heart attacks and stable angina.

Reasons for aspirin withdrawal included dental treatment, minor surgery and non-compliance.

The decision to discontinue aspirin therapy in coronary patients should not be taken lightly, and alternative recommendations should be considered, said the researchers.

The study was presented at Chest 2003, the annual assembly of the American College of Chest Physicians.

For more information:

www.chestnet.org

Sulfonamide reaction link

Patients with a history of hypersensitivity to sulfonamide antibiotics have an increased risk of reaction to non-antibiotic sulfonamide drugs and penicillins, say USA researchers.

The study found that nearly 10 per cent of patients with a history of sulfonamide allergy reacted when administered a non-antibiotic sulfonamide. Fewer than 2 per cent of previously non-sensitive patients had a reaction under the same conditions.

However, the association between primary and subsequent allergic reactions appeared to be due to a predisposition to allergic reactions rather than cross-reactivity with sulfonamides. This was illustrated by patients with prior evidence of hypersensitivity to penicillin:14 per cent of this group exhibited allergies when exposed to a non-antibiotic sulfonamide.

The main sulfonamide antibiotic used in the study was co-trimoxazole. The major non-antibiotic sulfonamide drugs in use are thiazide and loop diuretics, oral sulphonylurea anti-diabetics and sulfasalazine.

For more information:

N Engl J Med 349; 17: 1628-1635

www.nejm.org

Levodopa 'wearing off' effect in Parkinson's

Patients with Parkinson's disease taking levodopa may experience the drugs' effects 'wearing off' earlier than their healthcare providers realise, say researchers in the USA.

In a study of over 300 patients with Parkinson's disease, clinical assessors identified 'wearing off' in 85 patients (29.4 per cent) compared with 165 patients (57.1 per cent) who self-reported 'wearing off' symptoms.

Dr Robert Hauser, a Parkinson's expert, said: "Although levodopa remains the foundation of Parkinson's disease therapy, the medical community has long recognised that its use can be limited due to the inability to control Parkinson's disease symptoms over time." He added: "However, this study shows that end-of-dose 'wearing off' may be a bigger problem for Parkinson's disease patients than physicians and other members of the healthcare community realise."

The data was presented at the Parkinson's Study Group meeting in San Francisco.

● Orion Pharma has received EU-wide marketing authorisation for Stalevo (levodopa, carbidopa and entacapone) for treating Parkinson's disease from the European Agency for the Evaluation of Medical Products. It is indicated for patients who are experiencing end-of-dose 'wearing off' symptoms. Orion will launch the product in some European countries before the end of the year.

SSRIs lower suicides

Older male adolescents are less likely to attempt suicide when treated with SSRIs, say researchers in the USA.

This is probably because older patients are more likely to have a diagnosable condition and could benefit more from antidepressants than younger patients.

Analyses that link regional increases in antidepressant medication use and increased suicide rates may simply be because communities with high suicide rates tend to use more antidepressants, the authors say in *Archives of General Psychiatry*.

A 1 per cent increase in SSRI use meant a 0.23 decrease in the number of suicides per 100,000 adolescents a year. However, the authors found disappointing results with tricyclic antidepressants.

For more information:

Arch Gen Psychiatry 2003; 60: 978-82

www.archgenpsychiatry.com

Scriptlines

Aquaform shrinks

Unomedical is introducing an 8g size to the Aquaform hydrogel wound dressing range.

The product has been launched in response to nurses' demands for a smaller size than the existing 15g. Although the product is not currently prescribable on FP10, the company hopes to have the new size listed in part IX of the *Drug Tariff* in January.

Price: £14.50

Pack size:10
Pip code: 300-7861
Unomedical Ltd
Tel: 01527 587700.

Solian special container

PSNC's National Prescription Research Centre has been advised that Solian Oral Solution (amisulpride 100mg/ml) will be classed as a special container for prescriptions dispensed from November 2003.

For more information:

National Prescription Research Centre
www.psnc.org.uk
Tel: 020 8441 8427.

Plavix SPC changes

Sanofi-Synthelabo and Bristol-Myers Squibb have updated the SPC for Plavix (clopidogrel).

Three E numbers have been added to the list of excipients – mannitol (E421), hyprocellulose (E464) and triacetin (E1518).

The following very rare side effects have been added: vasculitis, hypotension, colitis and pancreatitis.

For more information:

www.medicines.org.uk
Sanofi-Synthelabo
Tel: 01483 505515
Bristol-Myers Squibb
Tel: 020 8572 7422.

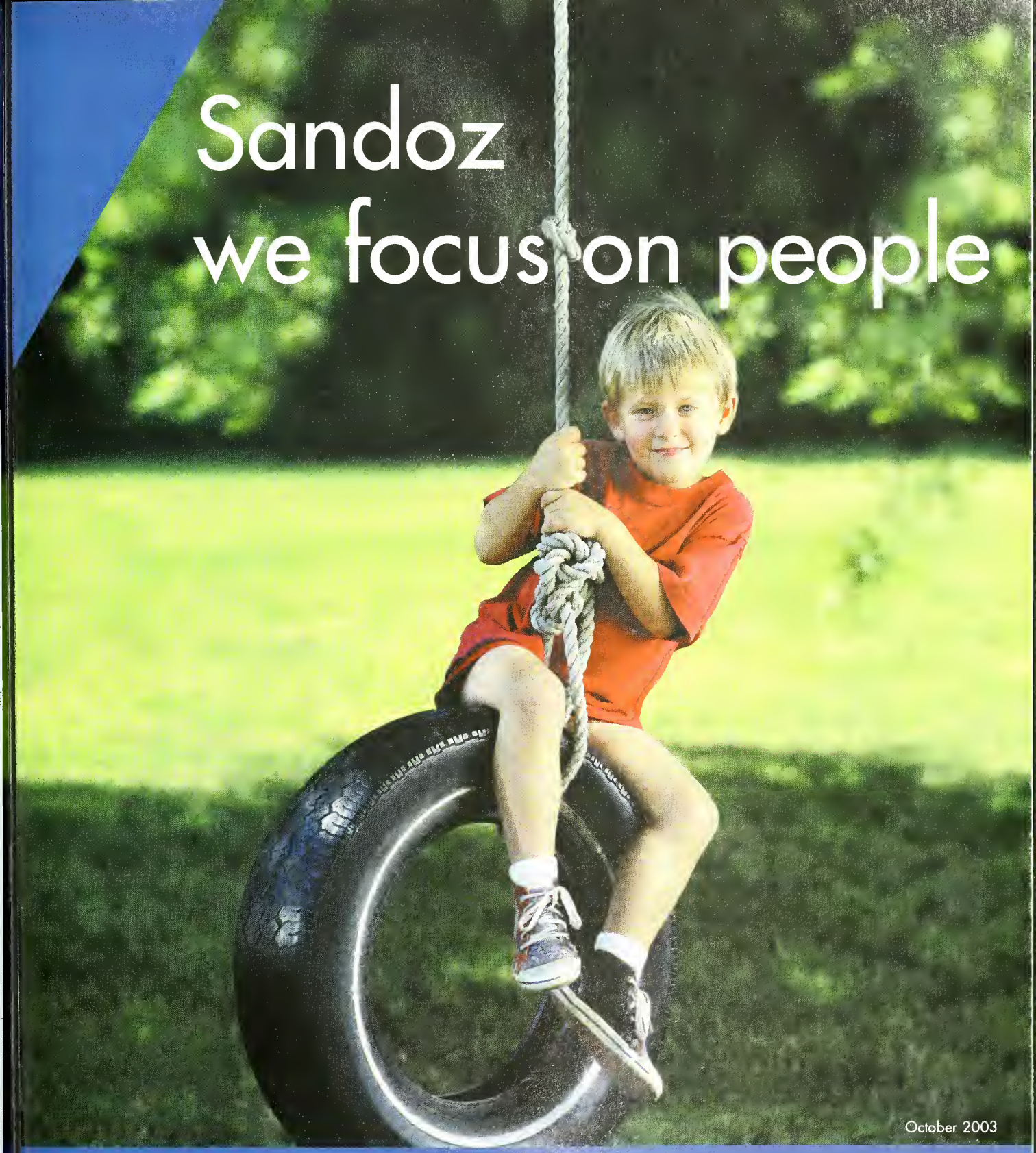
Ostomy product

Confidence Gold Soft and Secure is a new ostomy product from Salts Healthcare.

The drainable pouch has an integrated hook and loop closure claimed to lock securely even when wet. The product's flexible strips open the spout with a gentle squeeze and it has a multi-layered filtration system to help odour control.

For more information:

See *Price List*
www.salts.co.uk
Salts Healthcare
Tel: 0121 333 2000.



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Think Generics

Vapour Drops add to Covonia range

Thornton & Ross is extending the Covonia range with the introduction of Covonia Vapour Drops.

The drops contain menthol 17.5 per cent w/v and peppermint oil 0.2 per cent v/v and have been designed to be sprinkled onto a handkerchief to relieve nasal congestion, hayfever and catarrh symptoms.

The product is not suitable for use in children under three months.

A TV advertisement will run from November until February on terrestrial and satellite TV channels. The product is available direct or from wholesalers, and is initially only to be sold from pharmacies.

Price: RSP £2.29

Pack size: 15ml
Pip code: 294-6655
Thornton & Ross Ltd
Tel: 01484 842217.

Potter's makes TV debut

Potter's has launched its first TV campaign with advertisements for its four best-selling products.

Elixir of Echinacea and Vegetable Cough Remover are the first products to be promoted in a series of animated adverts running on GMTV from October 20.

The £1 million campaign will then focus on Tabritis (for aches and pains) in March, followed by Antifect (for hayfever) in May.

Price: see *Price List*

Pip codes: see *Price List*
Potter's Herbal Supplies
E-mail: email@pottersherbals.co.uk
Tel: 01942 405100.

Makeover for Alldays

Procter & Gamble is updating its Alldays pantyliner brand with the introduction of four new variants and new look packaging across the whole range.

The new variants are Ultra Light (extremely thin), Ultra Light Fresh (extremely thin and scented), Extra Large (soft, flexible and secure) and Extra Long Plus (twice the protection of two normal liners).

Price: RSP £2.09

Pip code: see *Price List*
Procter & Gamble UK
Tel: 01932 896000.

Elite pouch for Topman

SSL International is launching a safer sex initiative by making Durex Elite condoms available in branches of Topman from November 10.

Three Elite condoms will retail in a matt black 'Pocket Pouch' specially designed to fit in a back pocket, with silver refills available separately.

The products will be merchandised at tillpoints along with safe sex leaflets.

For more information:

SSL International Plc
www.durex.com
Tel: 0161 654 3000.

TV next week

Aquafresh: All areas except U, CTV, GMTV
Askit Powders: STV, C4, C5
Clearblue Digital Pregnancy Test: All areas except U, CTV, GMTV
Horlicks: B, G, Y, TT, C4
Lloydspharmacy's Diabetes Testing Service: GTV, STV, B
Lucozade Sport: All areas except U, CTV, C4, C5, GMTV
Nivea for Men Revitalisng Q10: All areas
Nivea Visage Age Reversal cream: All areas
Oilatum Scalp Treatment: Sat
Panadol ActiFast: U
Ribena: All areas except U, CTV, GMTV
Sensodyne Total Care Extra Fresh: U
Seven Seas Neutra Taste: C5, GMTV, Sat
Seven Seas Pure Cod Liver Oil: C4, C5, GMTV, Sat
Solpadeine: U
Tena *lady* & Tena *pants* Discreet: All areas except U, GMTV
PharmaSite for next week: Tixyplus – window, **Care range Fluconazole –** in-store, **Metanium –** dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Frontshop

Aquafresh takes a shower

The four-week advertising campaign for Aquafresh Extreme Clean launches on national television on November 1.

Called 'Showerbox', the advert shows a woman cleaning her teeth in the shower, to suggest that the product feels like a shower for your mouth.

Computer graphics demonstrate how the paste's micro-active foam works between the teeth "to give a really invigorating clean". It ends with the strapline: "New Extreme Clean from Aquafresh. Take the feeling of clean to the extreme!"

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637.

Glutano extends range

Gluten Free Foods has added Luxury Ginger Cookies to its Glutano range.

The chocolate covered ginger biscuits are gluten, wheat, egg and soya free and are not NHS prescribable.

Price: RSP £2.49
Pack size: 150g
Pip code: 300-7960
Gluten Free Foods Ltd
Tel: 020 8953 4444.

Fisherman's Friend bites back

Jenks is promoting the Fisherman's Friends range of throat lozenges, including the newly launched Cherry Menthol flavour, with a £1 million advertising campaign.

The new cherry flavour contains no added sugar and is available in two pack sizes.

Advertisements using the taglines "Try a drop of the strong stuff" and "When frost bites, bite back" will run in national newspapers and specialist outdoor pursuit magazines.

Accompanying outdoor posters will promise "relief from extreme conditions" and trade advertising and promotions will add further support. The campaign will run until February.

Price: RSP £0.65 (25g); £1.25 (45g)
Pip code: 25g 296-3767; 45g 296-3742
Jenks Sales Brokers
Tel: 01844 295900.

Report Webstar Health Conference

Doing dispensing differently...

...this was the title of a Webstar Health conference which debated the impact of automation and skill mix on pharmacy's future. Gary Paragpuri was there

Much of the Government's pharmacy agenda will have a huge impact on the way that dispensing is carried out in the future.

The dispensing fee looks set to be cut, with the money being transferred to provide patient centred clinical services. In the DoH's *Vision* document, the chief pharmacist lists 10 key roles for pharmacy and only one of these relates to dispensing. However, this does not mean dispensing is not important as it provides context for the other nine roles, said Magnus Hird, Blackpool PCT's medicines management head.

Nonetheless, PCTs want a cheaper dispensing service. Although there is no funding to develop the dispensing role, it remains a key service because at some time all of the PCTs' patients will use it. PCTs require the service to be safe, efficient, quick, able to reduce workload from GPs and secondary care and come with added value such as health promotion and waste reduction.

In addition to PCTs' needs, other drivers that will apply pressure on the service to evolve are control of entry and the new pharmacy contract. If the Government deregulates the market, would pharmacists be prepared to stake their income on something that was open to competition, and will the contract be the new control of entry as only PCTs will be able to commission services, asked Mr Hird.

Furthermore, dispensing volume will increase as GPs hit prescribing targets such as those for statins. This increased workload will be compounded by the fact that it will take several years for pharmacy schools to produce more pharmacists. Many pharmacies and pharmacists are already at the limit of what they can safely do in a day, and the bottom line, said Mr Hird, is change or there will be no future.

If pharmacists stay as they are, then they will not be able to cope as the volume of dispensing rises, he said. Others may spot the gaps in pharmacists' services and could potentially take over some roles, he suggested.

Although technicians that can dispense and check prescriptions could help to free up pharmacists' time, they will take time to train and demand higher wages. This may not be viable but could form part of the final solution, said Mr Hird. More likely options include the merger of pharmacies, a 'hub and spoke' dispensing model and wholesaler dispensing, he suggested.

A merger between two local pharmacies could produce economies of scale. By employing both pharmacists and utilising trained technicians, the business could cope with a higher volume of dispensing and provide additional services. But the risk is that a competitor may now enter the market because previously where there were two pharmacies there is now only one.

The 'hub and spoke' model could be used by a multiple pharmacy which has a large number of branches in an area. A central hub, located in an out-of-town low rent area could provide all the dispensing for the branches in the area. The high dispensing

“If you don't know what you are looking for how can you spot it?”

Colette McCreedy

Magnus Hird

volume would be suited to automation and would cut costs further. An IT link between the branches – or spokes – would allow PMRs to be shared, and so patients could choose the most convenient 'spoke' to collect their medicines.

The disadvantages of this model are that staff will be unlikely to enjoy the repetitive nature of the work at the hub, and patients may gravitate to certain spokes, such as those located at supermarkets, threatening the viability of other spokes.

Wholesalers who own retail pharmacy chains could also use the hub and spoke model. They already use automation and have suitable premises, but what will they charge for the service, asked Mr Hird.

Despite automation's benefits, it cannot be used in isolation, as pharmacists' experience will also be needed, he added.

NPA pharmacy practice director Colette McCreedy asked if the expanding role of technicians could result in the pharmacist's role being made redundant.

The Government has said that it intends to consult on the possibility of technicians dispensing and selling some P medicines but with the caveat that pharmacists retain final responsibility. For some pharmacists this will be welcome news, as it will free time to attend meetings with GPs or to provide other clinical roles, said Ms McCreedy. But for a large number of pharmacists this is verging on heresy, she said, because they see themselves as inextricably linked to the dispensing process.

Pharmacists may argue that for every prescription, they perform a pharmaceutical assessment and a final check. But in reality do pharmacists always assess each prescription for issues such as dosage, interactions, appropriateness, compliance and therapeutic duplication? They would be able to concentrate on the pharmaceutical assessment if they separated it from the final check by doing the assessment at the beginning of the process in front of the patient and delegating the accuracy or final check to support staff.

Regarding the final accuracy check, anybody who could competently assemble a prescription could become competent to check the assembly process, suggested Ms McCreedy.

However, one of the reasons pharmacists are reluctant to give up this role is because they are so diligent and would only delegate if they were absolutely certain that it was carried out to the best standards, she said.

A seperate issue is whether pharmacists can delegate the pharmaceutical assessment. "The crux of the problem is how this can be delegated." If pharmacists delegate the pharmaceutical assessment to technicians, then they are relying on someone who knows less than them, and if you don't know what you are looking for how can you spot it, asked Ms McCreedy.

Even technicians agree that if they were to perform this role, they would require a higher level of training coupled with experience, a scenario similar to pharmacists taking on

upplementary prescribing roles.

Such 'super-techs' could perate under standard operating rocedures, allowing pharmacists o leave the premises for short eriods. If pharmacists are free to eave for short periods, what's to top them from leaving the remises full time and only emotely supervising the business, suggested Ms McCreedy.

Could the Government's desire to free pharmacists to perform other roles be because it wanted to pay less for the dispensing service, she suggested. For example, when parallel imported drugs first appeared, many pharmacists were reluctant to use them because of quality concerns but the Government forced pharmacists to use them by applying a discount clawback on all contractors, whether or not they used PIs. If the Government devalues the dispensing service, pharmacists could again lose out and so it is important for all pharmacists to be involved in the debate, she said.

One factor which could make this debate redundant is the value that patients place on pharmacists. The NPA's 'Ask Your Pharmacist' campaign has been successful in highlighting pharmacists' role in treating minor ailments and offering medication advice without an appointment. As a result patients expect pharmacists to be on the premises when they visit.

Third party errors still a problem

If pharmacists delegate dispensing to technicians or outsource dispensing to a third party the pharmacist remains responsible for any dispensing errors. Pharmacists cannot contract out of liability, said David Reissner from Charles Russell solicitors.

Examining the legal implications for a community pharmacy, which contracted its care home dispensing to a third party, he asked that if the third party premises did not have an NHS contract, would the medication have to be rechecked at the pharmacy?

There is no easy answer, he said. One possibility to avoid rechecking the medicines would be for the pharmacist to conduct a random audit of the medication dispensed at the third party premises. To date, no one, including the RPSGB, had objected to this proposal.

Robot has spare capacity at night

A £500,000 dispensing robot at Chelsea and Westminster Hospital has halved stockholding, reduced pharmacists' workload in the dispensary, cut patients' discharge times and reduced the incidence of patients missing medication doses.

Problems with staff recruitment, retention and the massive workload were behind the decision to introduce the robot, according to Chelsea and Westminster NHS Trust's chief pharmacist Pippa Roberts.

The robot has helped alleviate the "massive pressure" faced by staff, who dispense 40,000 in-patient, out-patient and discharge prescriptions per month. In addition, they carry out about 400 prescription interventions per five days.

The hospital's robot is capable of storing and dispensing both fridge lines and CDs and includes an integrated labelling system. It has 2km of internal shelving and a 45,000-pack capacity, and takes

20 seconds to pick the first item and 10 seconds for subsequent items. It has freed up two pharmacy assistants, two technicians and 1.5 pharmacists from the dispensary so far.

However, as the robot only operates fully during the day, it has spare capacity at night and weekends to take on a dispensing service for other contractors.

Robot is 'a viable option'

Grays Pharmacy in Berwick-upon-Tweed is the second community pharmacy in the UK to install a dispensing robot.

Relocation into a small and awkwardly shaped dispensary in a health centre forced proprietor Andrew Gray to consider new ways of working to cope with the increase in workload, and following a visit to a German community pharmacy he chose to install the robot.

He said the benefits are increased reliability, an elimination of picking errors, faster and more efficient dispensing, a stock audit trail and more free staff time. Each technician can now work individually and there are no bottlenecks in the dispensing process, he said.

The robot reads the barcodes on packs and scans the product's physical dimensions. It then places the pack in an appropriately sized space to make best use of its storage space. Although only half of the robot's capacity is currently being used, it still holds 5,000 packs and there are many years of expansion left, said Mr Gray.

It was also not as expensive as he first feared. Despite costing six figures, Mr Gray said that it was classified as computer technology and so 100 per cent of the cost was tax deductible. He added that even though his business was not a 'script factory', the robot was a viable option.

For the future, Mr Gray said the robot would check orders, automatically label packs and produce 'real time' stock levels. In addition, the introduction of ETP would eliminate transcription errors.

Technicians accredited by PCTs?

The shortage of pharmacists could result in technicians becoming accredited by PCTs for the provision of services.

Although this would depend on the type of service, it could include areas such as patient domiciliary visits and the supply of monitored dosage systems, according to Moss Pharmacy's pharmacy practice lead Paul Griffiths.

In some Moss branches a second pharmacist was employed to assist with dispensing for care homes, and by using an accredited checking technician instead of the second pharmacist this would produce considerable savings on the wage bill, he said.

On the subject of centralised dispensing, Mr Griffiths said that this could be used for care homes and repeat dispensing and would free pharmacists' time for other roles.

Remote supervision is essential as it allows pharmacists to carry out domiciliary visits and participate in clinics and GP meetings, suggested Mr Griffiths.

Furthermore, if pharmacists remain reluctant to embrace remote supervision then technicians could have an opportunity to perform clinical roles. However, a major concern is that the public may perceive a service provided without a pharmacist as second rate.

Designs on the

Pharmacogenomics will dramatically change the way pharmacists work and 10 year from now pharmacy may be a very different animal, reports Gary Paragpuri

In the movie *Groundhog Day*, the central character is trapped in the same day. No matter what changes he makes to his daily routine, he cannot escape. For all pharmacists' efforts to establish new services such as repeat dispensing, medicines management, monitored dosage supply, diagnostic testing and minor ailment services, their core job remains the same, much like the movie.

Doctors diagnose and prescribe, while pharmacists dutifully follow their instructions. Consequently medicine supply remains the mainstay of what pharmacists do.

But this will change. The new pharmacy contract will ensure pharmacists' contribution to patients' clinical needs is recognised and rewarded, and pharmacists will, hopefully, no longer be seen as just 'pill counters'. Pharmacy technicians will take over the dispensing role, while pharmacists will diversify and take on greater responsibility for patient care.

One of the biggest impacts on the way pharmacists work in the future will be the science of pharmacogenomics (also referred to as pharmacogenetics). This is the study of how genetic variation affects our response to medicines, and will allow drugs to be tailored to individual patients to ensure maximum benefit and minimum adverse effects.

In the following articles, three experts give their views on how pharmacogenetics will impact on pharmacy.

The periodic table of life

The idea of giving the right medicine at the right dose to the right patient at the onset of treatment could soon be commonplace, according to Professor Saghir Akhtar, chair in drug delivery and director of the Centre for Genome-based Therapeutics at Cardiff University's School of Pharmacy.

Now that the complete human genome has been sequenced, it is only a matter of time before science produces a 'periodic table of life' in which we will have a complete listing of all the genes, their structure and function, and their relationship to disease.

"This will happen for every given cell, organ and tissue. It's a mammoth task but one that's well on its way to happening in the near future," he says.

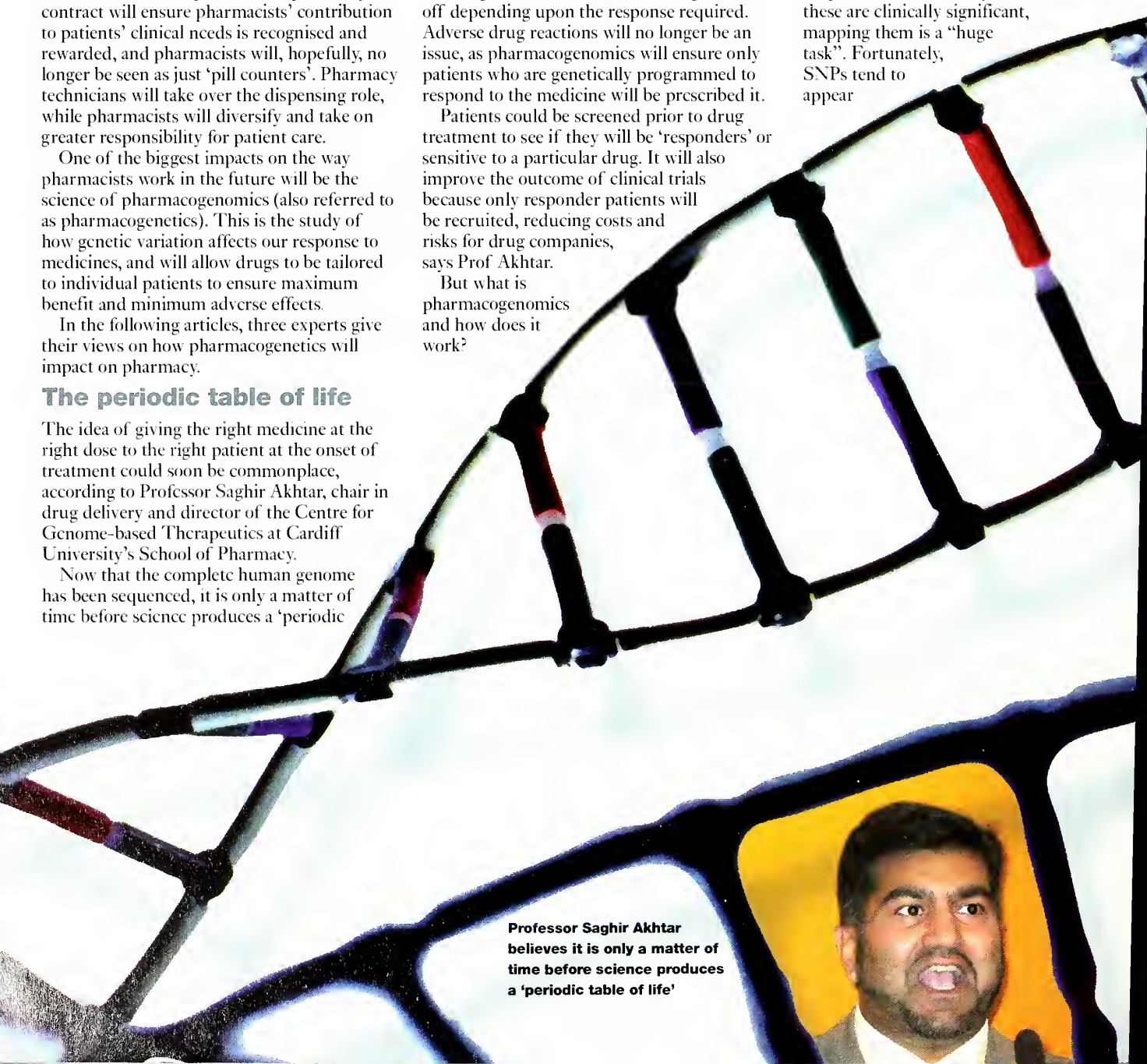
Pharmacists will use pharmacogenomics to identify patients with a predisposition to disease and initiate prophylactic treatment. There will be better-targeted medicines, specifically designed for a given target in a particular patient population, says Prof Akhtar. These 'gene medicines' will switch genes on or off depending upon the response required. Adverse drug reactions will no longer be an issue, as pharmacogenomics will ensure only patients who are genetically programmed to respond to the medicine will be prescribed it.

Patients could be screened prior to drug treatment to see if they will be 'responders' or sensitive to a particular drug. It will also improve the outcome of clinical trials because only responder patients will be recruited, reducing costs and risks for drug companies, says Prof Akhtar.

But what is pharmacogenomics and how does it work?

Everyone's gene sequence is 99.9 per cent identical, says Prof Akhtar, and it is only 0.1 per cent of the genome which produces people's variation in drug response. Most of these variations can be further pinpointed to single nucleotide polymorphisms (SNPs).

For example, an amino acid sequence such as TACG may mutate to TATG, and this single nucleotide change will cause a different protein to be coded which may produce a different response to a specific medicine. It is estimated that there are about three billion nucleotide variations, says Prof Akhtar, and despite the fact that only about 10 million of these are clinically significant, mapping them is a "huge task". Fortunately, SNPs tend to appear



Professor Saghir Akhtar believes it is only a matter of time before science produces a 'periodic table of life'

future

Prof Akhtar's vision

In the future, a patient diagnosed with cancer will routinely be referred to a specialist pharmacist for treatment. The pharmacist will carry out a genetic profile of the patient or upload an existing one from the patient's smart card. This, and the diagnosis, is fed into a computer which uses pharmacogenomics software to decide the best treatment option.

Of the four drug options available the computer produces a prescription for drugs A, C* and D. Despite being a commonly prescribed option, drug B is excluded because the genetic profile shows the patient carries a gene which inactivates B. Drug C is asterisked by the computer because it needs to be administered in a higher than normal dose because the genetic profile shows that the patient carries a gene which partially metabolises drug C.

The pharmacist then counsels the patient and explains the course of treatment.

in set patterns and blocks, called haplotypes. As these are an inherited characteristic, it is possible to use differences in haplotype inheritance between individuals to explain different drug responses.

Pharmacogenomics may sound a thing of the distant future but a drug, which is only prescribed in conjunction with netic profiling, is already available.

Metastatic breast cancer is associated with a netic variation. About a third of patients ith the disease will overproduce a protein lled HER2.

The main treatment option, Herceptin, is ost effective in this particular cohort of tients, and consequently patients must be reened prior to initiating treatment to ensure ly 'responder' patients get the drug.

Genetic testing here to stay

Genetic testing is already a significant market, with sales exceeding half a billion dollars in the USA and with over 900 genetic tests available to the public. In addition, almost all drugs on the market have some data on drug/gene interactions, suggesting genetic testing is here to stay.

It will be pharmacists' ability to communicate scientific data to consumers which will be a major factor in ensuring the success of pharmacogenomics. Community pharmacists will need to deliver personal information to patients from the sophisticated information provided by genetic testing, says Dr Gareth Roberts, Sciona Ltd's healthcare director.

Evidence from the USA shows that, by providing a personalised report, pharmacists can motivate people to make changes to their lifestyle or diet. Conditions such as diabetes, hypertension, high cholesterol and osteoporosis are good examples of areas where information given by pharmacists can motivate people to make lifestyle changes, Dr Roberts suggests.

Although there are risks involved with genetic tests, such as ensuring patient consent, protecting data from insurers, compliance with DNA storage regulations and liability for patient outcomes, these are no different to existing risks, he argues. Furthermore, there are several problems in current treatment models. Protocols for evidenced-based medicines are derived from data pooled from large-scale studies. As a result, standardised protocols are applied to all patients, which means that many patients do not get the best treatment first time or get the wrong treatment initially. This delay can lead to further deterioration in the patient's condition.

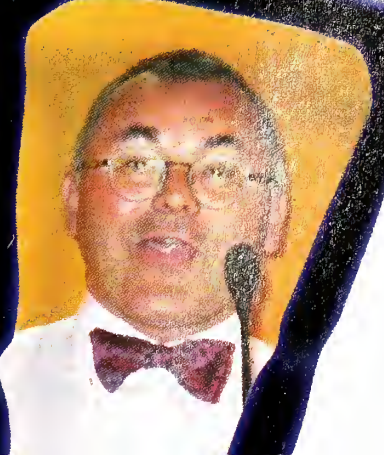
Possible problems

Before the concept of personalised medication is introduced, several ethical issues will have to be addressed. Patients may demand screening to ensure the medicine will work. Drug purchasers such as the NHS may restrict medication use to those patients deemed responders, and as a result the pharmaceutical industry could charge higher prices to get its 'pound of flesh', suggests Paul Rolan, Medeval medical director and consultant physician at Manchester Royal Infirmary.

In addition, health professionals must ensure advice to patients is evidence based, but this could prove difficult as it may take many years to build data on genetic testing and clinical outcomes, suggests Dr Rolan.

The use of pharmacogenomic data will mean that physicians may not be the best prescribers in the future, and this might be a future role for clinical pharmacists or therapy specialists, he says.

Continued on page 30



Dr Gareth Roberts thinks pharmacists have a major role in ensuring the success of pharmacogenomics by communicating scientific information to the public

Manufacturers and wholesalers will be key in supporting community pharmacists utilise genetic developments and they will be keen to play a part in the future. Four leading players give us their views

Making the future

AAH Pharmaceuticals marketing director Mandeep Mudhar

"When customers enter the pharmacy, one of the first people they will see will be the pharmacist. Technicians will effectively be managing the dispensary, freeing the pharmacist to be in the front line dealing with patients as they come in. Prescriptions will arrive at the pharmacy in an electronic format, which will allow the pharmacist to check the dispensed products earlier.

The flow of patients in pharmacies will be very different. Instead of the patient handing their prescription to an assistant to be passed to the dispensary, in future patients will get full-on contact with the pharmacist. This represents a wonderful opportunity for pharmacists to develop specialisms. If the local population has a particular health need such as diabetes or CHD, pharmacists could tailor their behaviour, products and linkages to information leaflets, to concentrate on that area. If service provision is the way forward and you are being paid for it, why not make yourself a specialist in an area. Pharmacists are not going to be masters of all trades.

Technological advances are bringing down the cost of diagnostic testing equipment, while reliability and technical performance is going up. However, the danger is that in the future diagnostic tests will be packaged for people to take home. What pharmacy has to do is link their diagnostic service with other services such as medicines management. In 15 years time, doctors will diagnose and pharmacists will prescribe."

Wellbeing Screening managing director Patrick Kirby

"At a recent meeting on the development of point of care testing, involving the British In-Vitro Diagnostics Association, the Association of Clinical Biochemists, as well as the Royal Pharmaceutical Society, there was a high degree of agreement concerning the evolutionary impact this sector may have on the delivery of healthcare in the UK.

As one of the keynote speakers, WHO consultant Dr Colin Connelly encapsulated the prevailing view of the community-based healthcare provision with his statement: "The biggest barrier to introducing point of care testing in both hospitals and the community is the way the health service operates its financial and management frameworks."

But before singling out the health service yet again, it may be worth looking at the wider picture. It would appear that there is a wide range of diagnostic technology currently available for use by pharmacists strengthened by quality control and educational procedures routinely available to support the effective use of the product and deliver reliable outcomes. Long awaited IT systems, which are crucial to maintaining, managing and transferring patient information, are nearing the point of reliability.

Pathology laboratories are keen to see workloads reduced, particularly in areas involving routine monitoring of the chronically sick. Such a trend would free up laboratory resources and time to develop and improve acute and critical care diagnoses.

Consumers are keen to use local pharmacy services rather than having to travel to hospital clinics or wait for appointments with overworked GPs. We are told that pharmacists themselves are keen to embrace the new opportunities emerging under the new pharmacy contracts. The major players are working on various plans to deliver different medicines management services, added value services and value for money. Pharmacy will need philanthropy possibly, sound commercial judgement certainly – but consumer loyalty and retention can no longer be underestimated or undervalued.

So given that all of the key participants are already singing from the same song sheet, why isn't the market developing more quickly? One easy scapegoat has always been government funding of the NHS. More recently 'silo budgeting' has entered the vocabulary of analysts and observers as a means of explaining the lack of progress in building and delivering consumer-focused community healthcare. Has there ever been a government that hasn't been blamed over its handling of the NHS and historically, has this central control seriously impeded the development of the pharmacy sector?

Another smokescreen may be the restructuring of the NHS and creation of regional PCTs. Yes, it has taken time for these bodies to evolve and begin to deliver, but are things changing yet? For patient-centric diagnostics and treatment within the community to develop, there remain a number of central issues to consider.

Continued on page 3

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- Unlike pharmaceutical compounds, diagnostics are far less profitable; the more complex the test or outcome obtained, the longer it takes to relay the outcome to the consumer.
- Unlike POMs that are typically free at the point of use, certain diagnostic testing may have to be funded in part by the end-user and the pharmacy will expect to make a profit.
- On a cost per test basis, the centralised laboratory will always have a distinct advantage given that they do not have to make any sort of profit or pay rents or business rates.
- Redistribution of NHS funding will take place in order to support community-based healthcare provision but how will this funding be allocated? Will PCTs offer contracts to local pharmacies to undertake and perform selected diagnostic testing within the community, accepting that potentially the unit cost may well be higher than the equivalent services provided by the local pathology laboratory?

In addition to managing the mechanics of an evolving NHS, the activities of PCTs and finally the funding, pharmacists themselves have to embrace the opportunity. Merely setting up consulting rooms with a washbasin in one corner does not constitute community-based healthcare services.

Pharmacists will actually have to promote healthcare awareness to the community they serve far more than merely waiting for major pharmaceutical or OTC manufacturers to provide window posters or leaflets. If these issues are addressed within the industry then there there will be no areas of doubt.

Pharmacy Alliance general manager Alistair Marsh

"Community pharmacy is ideally placed to meet many of the future needs of patients under the new *Vision for the NHS*. The profession offers significant access benefits, plus skills and knowledge currently under-utilised within the primary healthcare team. The new contract proposals further emphasise the need for pharmacists to move from a product supply focus to a patient service focus.

While supporting the principles of many diagnostic initiatives, real progress will only be made in demonstrating pharmacists' impact on patient health outcomes by providing a first class, professional, medicine support service as part of broader medicines management patient care in collaboration with the healthcare team.

Providing patients and/or their carers with access to advice and support on both their condition and treatment will encourage ownership of both and lead to informed patient choice and thus concordance and positive patient health gain.

This is the future of community pharmacy services and Pharmacy Alliance provides a range of services to community pharmacists to ensure this change is possible, by:

- Enabling community pharmacists to demonstrate their value within the healthcare system.
- Facilitating quality service provision to patients by ensuring pharmacists utilise their existing skill mix and that they are suitably trained, motivated and supported.
- Enabling access to remuneration for provision of services that reflects the level of their professional input in enhancing patient care.
- Providing practical approaches to enable pharmacists to deliver in line with the Government's healthcare agenda.
- Shaping services around the needs and preferences of individual patients, their families and their carers.
- Responding to different needs of different populations.
- Working continuously to improve quality services and to minimise errors.
- Supporting and valuing pharmacy staff."

SureScreen Diagnostic principal scientific officer Jim Campbell

"There are many qualified healthcare professionals currently unable to take part in the NHS. If they could be included, the current workload of the health service could be reduced tomorrow. I am referring to two essential groups – pharmacists and occupational health workers. Pharmacists come into contact with the public more than GPs, and they carry out a vital role in filtering out people who would otherwise be troubling their doctor. These people are commercially placed to do so much more.

In addition, many companies have occupational health professionals who frequently treat their staff but at the moment cannot prescribe even the most basic of medicines, and they too could filter out many people who would otherwise need their doctor.

At the same time, rapid test technology has given the NHS a wide range of accurate, inexpensive tests that are as good as a laboratory test but only take a couple of minutes to perform. These could be used to diagnose a whole range of conditions and diseases, and monitor progress even while the patient is discussing their symptoms with the professional.

Screening has been playing an increasing role in healthcare year on year and this trend looks likely to accelerate. Tests include those for infectious diseases, metabolic imbalances, allergies and a range of 'well person' screens. These days, there is virtually a test for everything. A few years ago, screening was confined to GPs but sales of such tests direct to the public are growing all the time. In the future,

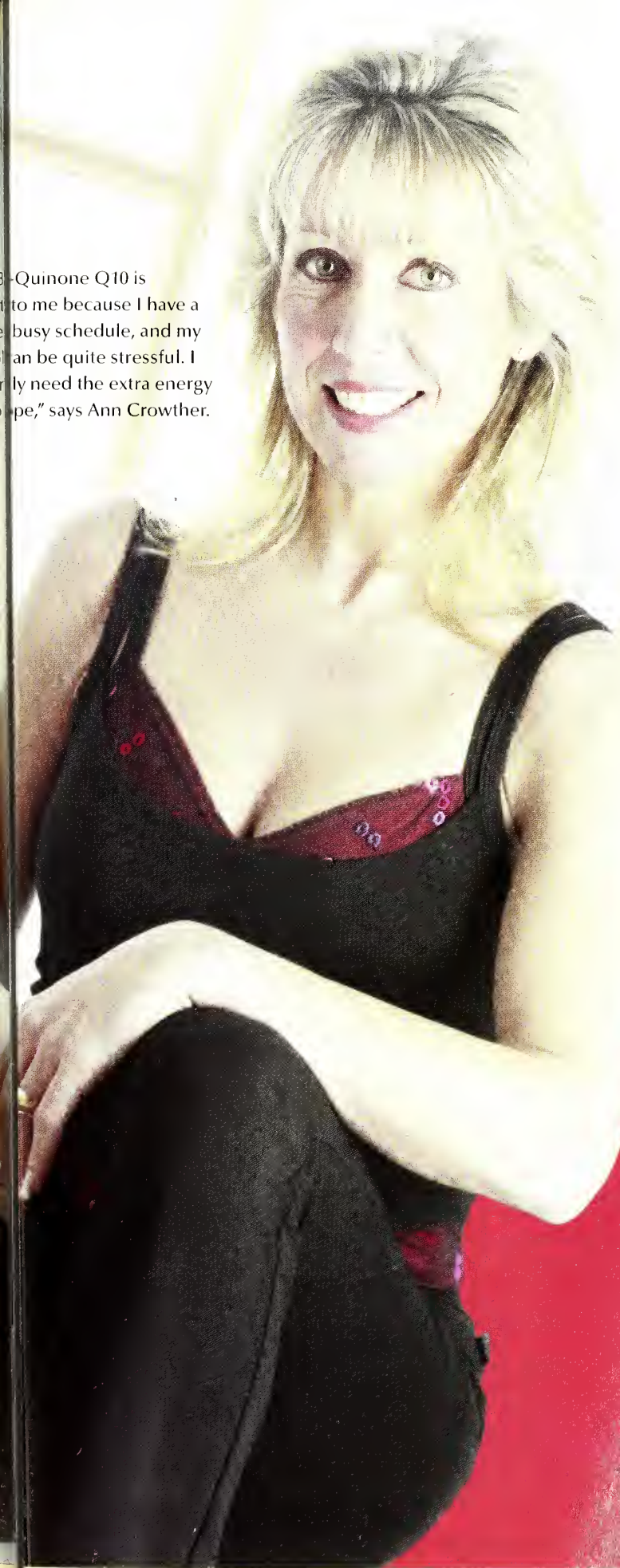
"Merely setting up consulting rooms with a washbasin in one corner does not constitute community-based healthcare services"

we think that pharmacists and occupational health practitioners will use screening routinely, then go on to prescribe treatments. Many people find this route acceptable because they get virtually instant results and can start treatment straight away.

Our vision of tomorrow's pharmacy? It depends to some extent on the size available. Small pharmacies will have displays of diagnostic tests and self-help medication based on alternative therapies. The pharmacist will prescribe medication and see the person when they next visit as a customer. This repeat visit will be another opportunity to sell products.

Customers requiring help with a diagnosis or test results will be referred to a call centre, website or main branch. They will lean on the manufacturer to support them with technical advice, phone calls and literature.

Large pharmacies will employ occupational nurses, possibly on a rota system, and perhaps a doctor to look after the enquiries and more serious needs. There will be an area for screening and consultation, which could also bring in custom for many smaller companies who promote screening. Customers will be able to walk in and seek consultation or book appointments. Charges will be made for these services and pharmacies will become one-stop shops for all their healthcare needs. The key players have this approach in mind, and so have the big four supermarkets."



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With a single stroke

Jeannette Smith suffered a stroke in April. Happily well on the way to recovery, she i now working again as a pharmacist near her home in Argyll. Here she relates her experiences on the receiving end of care...

You go to work on your 70th birthday as usual, embarrassed by the surgery staff serenading you and leaving one of those daft helium balloons behind the counter. By the end of the day all the locals know how old you are and you receive the congratulations with a touch of complacency.

The next day it's back to normal – until it is time to go home. Just before leaving you go across to the hotel to view the snazzy new jacuzzis in the extra rooms they've been fitting up, but while you're looking around you notice that one of your hands feels like a lump of dead meat. By the time you've crossed the road, words are echoing through your skull in a most peculiar way.

Travelling 50 miles backwards in an ambulance, you have time to wonder if you've just discovered the meaning of 'hubris'. All your life you've felt more or less in control, but you're strapped to a stretcher and can't even say the paramedic's name, Joe. It's one thing to joke that the only way out is feet first, but a very different thing when you can't explain why you keep wanting to giggle.

You are unloaded and parked beside a bed while a consignment of meals is being distributed. One of them is put on the table in front of you and you try to steer at least some of it into your mouth. A voice in the background asks if there were any relatives attached to "that woman in there". A junior doctor makes the best of a bad job, trying to fill in an admission form with the aid of a speechless patient.

You wish your husband had had a simple monosyllabic name. What's the point of asking questions when your tongue lolls about in your mouth refusing to obey? You manage to fish out your diary and point to the one number that will give them enough information for the time being. And all the time you're thinking that it's surely inadvisable to try to feed a stroke patient until the swallowing reflex has been checked.

You make surprisingly rapid progress. In a day or two, you're moved to the stroke rehabilitation ward, quite a step up in the world. From the windows, across the massed flowers, you have a glimpse of Loch Lomond. Fortunately, your tongue is not quite obedient enough for you to say the first thing that springs to mind when you're faced with the extravagant floral offerings, including some highly perfumed lilies. Your own visitors add to the flower show. You watch one of them disappearing down the corridor and try not to snivel in public. Apart from a great affection for the woman who has been working with you for more than six years, you can see the job you enjoyed, which has partly defined you for more than 40 years, walking down the corridor by her side.

Looking at some of the other patients in the ward, you begin to appreciate your own luck. Arms and legs quite soon begin to co-operate, meals go in the mouth if you're careful, and as one of the more able-bodied specimens you are taken down in the lift to sit in the sun in the garden.

The speech therapist reckons you will be able to go on improving at home without any specialist help. Is she sure? Conversations in the garden sound like a BBC Scotland situation comedy. Your English is as hard to speak as a foreign language. You can produce a few fluent sentences until you trip over a black hole in your vocabulary, and you can't spell when you play with the old Apple Mac in the day room.

Moving to a stroke rehabilitation ward is a step up in the wor

You are released with your new supply of drugs, which doesn't inspire confidence. Looking up a few references you can see that they may thin the blood nicely, but they don't address the underlying problem. Less than a week later you go into the surgery for an ECG and it's straight down the road again, though at least, this time, you don't have to travel the 50 miles backwards.

They ask many of the same questions they asked a fortnight ago, but this time you can answer for yourself. Then you're hooked up to a cardiac monitor – back to the dreaded commode again. In the ward you share a bay with a woman whose family history makes time fly. You try not to gawp at her visitors, trying to fit faces to the stories she's been telling.

You hope never to see her again. In such artificial intimacy you did something you haven't done since you were married, and made up your own history as you went along. What's the good of a story without a bit of spice?

The consultant, trailing her retinue, visits you. Without looking at you, she informs th juniors that this patient is to be started on warfarin and amiodarone, with a loading dose of 10mg tonight and three 200mg amiodarone for the first day.

If only you could have trusted your tong you would have said to her: "About time." I you have bouts of uncontrolled atrial fibrillation you have a high probability of stroke. When you move on to the next bed, you lie searching your brain for the name o the one patient on your computer who took amiodarone. The name obligingly surfaces, along with her recent death.

Now, when people ask you if you're keep better, you always say yes, if you don't coun the number of brain cells which have been wiped out. In spite of their medication you have stopped looking too far into the future

"Conversations in the garden sound like a BBC Scotland situation comedy. English is as hard to speak as a foreign language"

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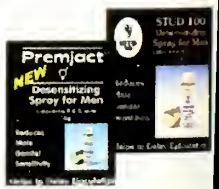

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Hillary Judd

First DataBank Europe has appointed pharmacist **Hillary Judd** as its head of knowledge base services, which maintains the Multilex Drug Data File. Ms Judd has joined from the British Pharmacopoeia Secretariat at the Medicines Division of the Department of Health.

Aventis has announced the appointment of **Julien Verley** as senior vice-president of corporate finance and treasury. Prior to this Mr Verley was general manager of the agricultural-biotech division at Aventis.

The 40th birthday of Paul Murray Plc has coincided with the appointment of **Charlotte Murray**, the third generation to work for the company. Ms Murray will be working in the public relations department, and has responsibility for the make-up portfolio, which includes the Miners Cosmetics range.


Malcolm Hardy


Ramji Chauhan


Peter Cross


Maureen Howson

Mawdsleys has appointed four new business development managers (BDMs). **Ramji Chauhan** has moved from Pharmaceuticals Direct to become BDM for North London; **Malcolm Hardy** is BDM for South Yorkshire and ha joined from Laboratoire Garnier; **Peter Cross** has moved from Seven Seas to be BDM for the North West, and **Maureen Howson** has moved from Trinit Sales and Marketing to become BDM for North Wales and Liverpool.

Will this be the Welsh Woman of the Year?

This pharmacist will find out later this month if she has been awarded the title of the *Western Mail* newspaper's 'Welsh Woman of the Year'.

Kerren Winmill of Tredegar, Gwent, right, has been shortlisted for the 'Woman in Science and Technology' category, and, if she wins, will go into the awards final.

She qualified from the University of Wales 26 years ago, and took a position with the Committee on Safety of Medicines. She then worked for Ciba-Geigy in Switzerland and the UK, before taking up her current role with Penn Pharmaceuticals. As its director of pharmaceutical services she has written articles on the new legislation affecting clinical research and has spoken at many conferences in the UK and Europe.

Kerren's nomination follows in the footsteps of fellow pharmacist Alison Sparks, a finalist in 1997 and 2001. This year's gala dinner and awards ceremony will be held at Cardiff International Arena.

Kerren said: "Being a finalist in the 'Woman in Science and Technology' category will hopefully encourage pharmacists to consider a career in industry. The opportunities are numerous and it can be fulfilling and rewarding."

Gam Singh Amar of Allesley Pharmacy, Coventry, is pictured receiving the winner's trophy from Alpharma's Roger Bell at this year's Nucare Annual Golf Competition. Sinking the final hole with 42 points, Mr Amar beat defending 2002 champion Neil Trew-Smith of Bell Chemists, Princes Risborough, Bucks into second place, while Pankaj Shah from Chemitex Ltd in Caterham, Surrey, came third. Alpharma sponsored this year's even the third to be held for Nucare members

Anyone for Champers?

Susan Hateley has been named the winner of C&D's Cambridge Counterpart course for August. She has worked at the Pelsall branch of West Midlands Co-op Pharmacy chain for two years. Both Susan and her supervising pharmacist Elizabeth Hammond were presented with a bottle of champagne from the course sponsor, Wyeth Consumer Healthcare. Fo more information on the Cambridge Counterpart counter assistant traini course contact Mary Prebble on 01732 377269

This was the crack squad sent to Norway to represent the UK at the Alpharma inter-company games championship as part of the company's centenary celebrations. The group's lack of experience at handball and volleyball did nothing to dent their enthusiasm, but sadly the squad failed to win any of their games, including the football competition. However, the event was so successful the company plans to make the games championship an annual event

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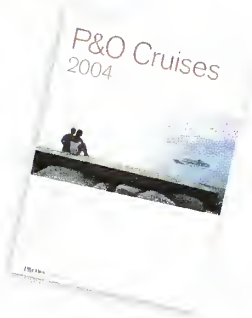

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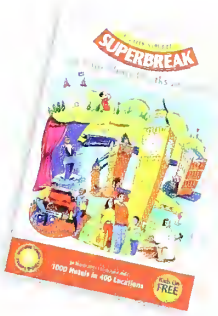

The republic of Ireland is perfect for short breaks year round and Superbreak feature a great selection of hotels in Dublin, Cork, Limerick, Galway and Wicklow – from 3-star to 5-star deluxe. Flights are available to Dublin from Luton, Stansted, Liverpool, Edinburgh, Newcastle and many other regional airports. Alternatively, why not take advantage of Superbreak's excellent rates in over 100 European locations – Barcelona, Bruges, Prague and Venice are just a few of the attractive historical cities featured.

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There's a sore throat treatment that can last longer than *dinner*, the kids' homework and a Bedtime story.

Strefen is clinically proven to reduce the symptoms associated with inflamed sore throats, providing rapid relief that lasts for up to 3 hours. They are the only lozenges to contain an NSAID (flurbiprofen) and have been shown to be well tolerated.[1] With a proven safety profile, Strefen is suitable for anyone suffering from sore throat pain to whom you would normally recommend an NSAID.

Recommend Strefen, because nothing is proven to last longer.

PRODUCT INFORMATION FOR STREFEN™ Strefen contains flurbiprofen BP 8.75mg per lozenge. **Indication:** Symptomatic relief of sore throat. **Dosage and administration:** Adults and children over 12 years: 1 lozenge sucked slowly every 3 – 6 hours as required, up to a maximum of 5 lozenges in 24 hours, and for a maximum of 3 days. The lozenges should be moved around the mouth whilst sucking. **Contraindications:** Hypersensitivity to any of the ingredients; in patients with existing, or history of, peptic ulceration; history of bronchospasm, rhinitis or urticaria associated with aspirin or NSAIDs. **Special warnings and precautions for use:** Bronchospasm may be precipitated in patients with history of asthma. Caution is required in: patients with renal, cardiac or hepatic impairment as renal function may deteriorate with use of NSAIDs; patients with hypertension; patients with abnormal bleeding potential as bleeding time can be prolonged. **Pregnancy and lactation:** Use of Strefen should be avoided in the third trimester. Flurbiprofen appears in breast milk in very low concentrations and is unlikely to affect the breast-fed infant adversely. **Undesirable effects:** Dyspepsia, nausea, v gastrointestinal haemorrhage, diarrhoea, mouth ulcers, fluid retention and oedema, exacerba peptic ulceration and perforation, urticaria, angioedema and various rashes have been reporte rarely, jaundice and thrombocytopenia (usually reversible), aplastic anaemia, and agranulocytos been reported. Transient local irritation of the buccal mucosa may occur, and taste perversion ha reported in trials. **Package quantities:** Strefen is available in cartons of 16 lozenges. **MRRP:** £3 lozenges). **Product licence number:** 00327/0135. **Product licence holder:** Crookes Healthc Nottingham NG2 3AA. **Legal category:** P. **Date of preparation:** August 2003. **Reference: 1.** B SI *et al*. Efficacy and tolerability of the anti-inflammatory throat lozenge flurbiprofen in the treatment of sore throat - A randomised, double-blind, placebo-controlled study. Clin Drug Invest 2001; **21**(3): 183-193. URT000251.

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To receive copies of the pharmacist and pharmacy assistant sore throat management training manuals or a clinical paper summary, telephone 0115 90

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